DME Happenings

Jurisdiction D
Issue No. 48
September 2015

In This Issue...

CONTACT US

FYI

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

Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select "Noridian E-mail Newsletter Sign Up" at the bottom of the left-hand navigation menu.

Noridian Healthcare Solutions, LLC

APPEALS

CERT

CODING

COMPETITIVE BID

COVERAGE

DOCUMENTATION

EDUCATIONAL

ENDEAVOR

ENTERAL AND PARENTERAL NUTRITION

EXTERNAL INFUSION PUMPS

GLUCOSE MONITORS

HOME HEALTH

HOSPITAL BEDS

ICD-10

IMMUNOSUPPRESSIVE DRUGS

IVIG

LCD AND POLICY ARTICLE REVISIONS

MOBILITY DEVICES

MODIFIERS

NEBULIZERS

NEGATIVE PRESSURE WOUND THERAPY

ORTHOTICS AND PROSTHETICS

OVERPAYMENTS AND REFUNDS

OXYGEN

PAP DEVICES

PRESSURE REDUCING SUPPORT SURFACES

REIMBURSEMENT

REMITTANCE ADVICE

RESPIRATORY ASSIST DEVICES

SURGICAL DRESSINGS

VACUUM ERECTION DEVICES

Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Mailing Addresses	
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian PO Box 6727 Fargo ND 58108-6727	**Benefit Protection** Noridian Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian PO Box 6737 Fargo ND 58108-6737	**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32231-4013
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian PO Box 6728 Fargo ND 58108-6728	**DME Recovery Auditor Overpayments** Noridian PO Box 6759 Fargo ND 58108-6759

CONTACT US

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

FYI

2015 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Event	Date	Closure Timeframe
Good Friday	April 3, 2015	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	April 10, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	April 17, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	April 24, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	May 8, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	May 15, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	May 22, 2015	9:40 a.m. – 12 p.m. CT
Memorial Day	May 25, 2015	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	June 12, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	June 19, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	June 26, 2015	9:40 a.m. – 12 p.m. CT
Independence Day Observance	July 3, 2015	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	July 10, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	July 17, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	July 24, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	August 14, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	August 21, 2015	9:40 a.m. – 12 p.m. CT
Off-the-Phone Training	August 28, 2015	9:40 a.m. – 12 p.m. CT

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.

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Good Friday	April 3, 2015	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	April 10, 2015	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	April 17, 2015	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	April 24, 2015	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 1, 2015	9:30 – 10:30 a.m. CT
Off-the-Phone Training	May 8, 2015	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 15, 2015	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 22, 2015	9:30 a.m. – 12 p.m. CT
Memorial Day	May 25, 2015	Entire Day Closed 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

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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

CMS Quarterly Provider Updates

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

NSV Initiative

MLN Matters® Number: SE1520

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all providers and suppliers, that enroll in the Medicare program and submit fee-for-service (FFS) claims to Medicare Administrative Contractors (MACs), including home health and hospice MACs, for services provided to Medicare beneficiaries.

What You Need to Know

This article provides the latest information about the Centers for Medicare & Medicaid Services (CMS) National Site Visit Verification (NSV) initiative. The NSV initiative is part of CMS' National Fraud Prevention Program (NFPP) and assists CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process.

Key Information

National Fraud Prevention Program (NFPP)

The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP enables CMS to proactively identify and respond to suspicious behavior, thus making the Agency more effective at fighting health care fraud than ever before. The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process by:

- identifying and preventing bad actors from enrolling in Medicare;
- identifying and removing bad actors that are already in the program; and

- identifying and preventing payment of fraudulent claims by responding with quick administrative action (e.g. enrollment revocations or payment suspensions).

National Site Visit Contractor: Ensuring Program Integrity at the Provider Enrollment Stage

In 2011, CMS implemented a site visit verification program using a National Site Visit Contractor (NSVC). The site visit verification program is a screening mechanism to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The NSVC will conduct unannounced site visits for Medicare Part A/B providers and suppliers. Site visits for Durable Medical Equipment (DMEPOS) suppliers and providers will continue to be conducted by the National Supplier Clearinghouse. The NSVC may conduct either an observational site visit or a detailed review to verify enrollment related information and collect specific information based on pre-defined checklists and procedures determined by CMS.

During an observational visit, the inspector engages in minimal contact with the provider or supplier and does not inhibit the daily activities that occur at the facility. The inspector may take photographs of the facility as part of the site visit. During a detailed review, the inspector will enter the facility, speak with staff, take photographs, and collect information to confirm the provider or supplier's compliance with CMS standards.

MSM Security Services, LLC was awarded the national site visit contract December 20, 2011. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits.

Inspectors performing the site visits will be employees of MSM, CES, or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

If the provider and/or its staff want to verify that a site visit has been ordered by CMS, please contact the respective jurisdiction's Medicare Administrative Contactor (MAC). MAC contact information can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf located on the CMS website.

If the provider and/or its staff wish to verify that an inspector is credentialed to complete a site visit verification, please call MSM Security Services, Monday through Friday from 7:00 a.m. to 8:00 p.m. ET at 1-855-220-1071. After 8 p.m., you may leave a message and the call will be returned the next business day.

Additional Information

To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" web page at http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp on the CMS website.

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.

Billing Procedures Related to the Department of VA - Reminder - Companion Information to MM8198

MLN Matters® Number: SE1517
Related Change Request (CR) #: CR 8198
Related CR Release Date: May 3, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1213OTN

Implementation Date: October 7, 2013

Provider Types Affected

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

Provider Action Needed

This article is intended to provide additional information and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services. This article is based on Change Request (CR) 8198 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1213OTN.pdf) which informs MACs about clarification to procedures for institutional claims related to the Department of Veterans Affairs (VA). Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) sent the MACs a letter (Technical Direction Letter #12002), entitled "Clarification to Procedures Related to the Department of Veterans Affairs (VA)". This communication advised MACs to no longer accept VA information entered on claims as the basis for assuming that Medicare should pay secondary. The Coordination of Benefits Contractor (COBC) also disabled the creation of VA Medicare Secondary Payer (MSP) records when an action to create such records was requested via the Electronic Correspondence Referral System (ECRS). The CMS took these actions based on the following language found in §1862(a) (3) of the Social Security Act (the Act): Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. ***VA claims, therefore, represents a Medicare program exclusion rather than an indication of MSP.***

Billing Instructions

For inpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program. VA approved services (that is, Medicare excluded services) may be submitted on a separate noncovered claim to Medicare. Only Medicare covered services should be billed to the Medicare program. Medicare **should not** be billed as the secondary payer to VA using the Value Code "42". (See the "Medicare Claims Processing Manual," Chapter 1, Section 60 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf for billing instructions).

For outpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services can be billed to Medicare. Medicare **should not** be billed as the secondary payer to VA using the Value Code "42". (See the "Medicare Claims Processing Manual," Chapter 1, Section 60 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf for billing instructions).

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.

MLN Connects Provider eNews Special Edition – June 2, 2015

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

From April 27 through May 1, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in a second successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

This second end-to-end testing week demonstrated that CMS systems are ready to accept ICD-10 claims. Approximately 875 providers and billing companies participated, and testers submitted over 23,000 test claims. View the results.

Overall, participants in the April end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. The acceptance rate for April was higher than January, with an increase in test claims submitted and a decrease in the percentage of errors related to diagnosis codes. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

In addition to acknowledgement testing, which may be completed at any time, a final end-to-end testing week will be held on July 20 through 24, 2015. The opportunity to volunteer for this testing week has closed. Testers who participated in the January and April end-to-end testing weeks are automatically eligible to test again in July.

Prepare Now for ICD-10 Implementation

Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015; or accept claims that contain both ICD-9 and ICD-10 codes.

There is still time to get ready!

Even though the October 1, 2015, mandatory implementation date is quickly approaching, providers still have time to prepare for ICD-10, and CMS has created a number of tools and resources to help you succeed. One tool is the "Road to 10," aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help you with implementation.

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 – June 4, 2015

MLN Connects® Provider eNews for June 4, 2015
View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Application Review — Last Chance to Register
- 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
- Hospital Compare Overall Star Ratings Methodology — Save the Date

- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

MLN Connects® Videos

- Prepare for ICD-10 with MLN Connects® Videos

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week through June 5
- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis

Announcements

- New Affordable Care Act Payment Model Seeks to Reduce Cardiovascular Disease
- New Medicare Data Available to Increase Transparency on Hospital and Physician Utilization
- Entrepreneurs and Innovators to Access Medicare Data
- DMEPOS Competitive Bidding Round 1 2017 — Get Licensed
- Quality Reporting Programs: 2014 eCQM Updates for 2016 Reporting

Claims, Pricers, and Codes

- July 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- "Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice of Noncoverage (ABN)" Web-Based Training Course — Released
- "Anesthesiologist Services with a Modifier GC in a Method II Critical Access Hospital (CAH)" Podcast — Released
- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets" Educational Tool — Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet — Revised

MLN Connects Provider eNews Special Edition – June 5, 2015

DMEPOS Competitive Bidding Announcement: Non-invasive Pressure Support Ventilators Removed from Round 1 2017

CMS has removed the non-invasive pressure support ventilators product category from Round 1 2017 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. For additional information, go to the HCPCS Decision Regarding Codes for Ventilators.

Note: This MLN Connects Provider eNews Special Edition was originally published on June 5, 2015. It is being republished to correct the title with the date of June 5, 2015 as June 6 had been listed in error. There is no change to the content of the article.

MLN Connects Provider eNews – June 11, 2015

MLN Connects® Provider eNews for June 11, 2015
View this edition as a PDF

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- Hospice Quality and Hospice Item Set Manual V1.02 — Last Chance to Register

- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Last Chance to Register
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Updated Results for ICD-10 End-to-End Testing Week in April
- Recognizing Men's Health Month and Men's Health Week
- CMS Finalizes Rules for Medicare Shared Savings Program
- Comprehensive Prevention Program Effectively Reduces Falls among Older People
- EHR Incentive Programs: Comments on Meaningful Use Proposed Rule Due June 15
- 2015 PQRS GPRO: 2 Weeks Left to Register by June 30 Deadline
- EHR Incentive Program: Deadline for Eligible Professionals Hardship Exception is July 1
- ICD-10 Resources for Medicare Providers

Claims, Pricers, and Codes

- 2016 ICD-10-CM Files, ICD-10-PCS Files, and GEMs Available
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Information and Resources for Submitting Correct ICD-10 Codes to Medicare" MLN Matters® Article — Released
- "Transcatheter Aortic Valve Replacement (TAVR) Hospital Program Volume Requirements" MLN Matters® Special Edition Article — Released
- "Revised and Clarified Place of Service (POS) Coding Instructions" Podcast — Released
- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article — Revised
- "Skilled Nursing Facility (SNF) Billing Reference" Fact Sheet — Reminder
- Medicare Learning Network Product® Available In Electronic Publication Format
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects Provider eNews – June 18, 2015

MLN Connects® Provider eNews for June 18, 2015
View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- ESRD QIP System Training — Save the Date
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Registration Now Open

- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Medicare Provides Coverage of HIV Screening
- Medicare and Medicaid 50th Anniversary Count Down
- Use New Interactive Case Studies to Explore ICD-10 Concepts
- Corrections to eCQM Measures for 2016 Reporting
- 2015 PQRS GPRO: 1 Week Left to Register by June 30 Deadline

Claims, Pricers, and Codes

- CY 2015 Home Health PPS Mainframe Pricer Software Available

Medicare Learning Network® Educational Products

- "Using the ICD-10-PCS New Technology Section X Codes" MLN Matters® Article — Released
- "Reminder to Billing Procedures Related to the Department of Veterans Affairs (VA) – Companion Information to CR8198" MLN Matters® Article — Released
- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article — Revised
- "General Equivalence Mappings Frequently Asked Questions" Booklet — Revised
- "ICD-10-CM/PCS Myths and Facts" Fact Sheet — Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet — Revised
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet — Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects Provider eNews – June 25, 2015

Editor's Note:

The October 1, 2015, compliance date for ICD-10 will be here in less than 100 days. Starting this week, your eNews has a new "Countdown to ICD-10" section, which groups all related information in one place to help you prepare.

MLN Connects® Provider eNews for June 25, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- ICD-10 Deadline: October 1, 2015
- ICD-10 Training Series for Small and Rural Practices
- Claims that Span the ICD-10 Implementation Date
- ICD-10 FAQs: CMNs, Prescriptions, and Orders
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality

- Transition to ICD-10 for Home Health

MLN Connects® National Provider Calls

- ESRD QIP System Training — Registration Now Open
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

MLN Connects® Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool — Webcast

Announcements

- Are You Providing an Annual Wellness Visit to Your Medicare Patients?
- Affordable Care Act Payment Model Saves More than $25 Million in First Performance Year
- National Medicare Fraud Takedown Results in Charges against 243 Individuals for Approximately $712 Million in False Billing
- Changes to the Medicare Opt-Out Law for Physicians and Practitioners
- Corrections to eCQM Measures for 2016 Reporting

Claims, Pricers, and Codes

- July 2015 Outpatient Prospective Payment System Pricer File Update
- CY 2015 Home Health PPS Mainframe Pricer Software Available

Medicare Learning Network® Educational Products

- Medicare Learning Network® Products Available In Electronic Publication Format
- New Medicare Learning Network® Educational Web Guides Fast Fact

MLN Connects Provider eNews – July 2, 2015

MLN Connects® Provider eNews for July 2, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- Results From June 2015 ICD-10 Acknowledgement Testing Week
- "ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" Fact Sheet — Revised
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls

- ESRD QIP System Training — Last Chance to Register
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Last Chance to Register
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

MLN Connects Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool — Webcast

Announcements

- Open Payments Posts Full Year of 2014 Financial Data
- Proposed CY 2016 Updates to Policies and Payment Rates for ESRD Facilities
- ACO Investment Model
- DMEPOS Competitive Bidding: Common Ownership and Control
- Physician-Owned Hospital Ownership Reporting: Release of the CMS 855POH
- AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture
- EHR Incentive Program: Discontinuation of EHR-Randomizer Application Effective July 1
- PV-PQRS: Transition from IACS to EIDM—Act by July 2

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set

Medicare Learning Network® Educational Products

- "Medicare Costs at a Glance: 2015" Fact Sheet — Released
- "Provider Compliance Tips for Computed Tomography (CT Scans)" Fact Sheet — Revised
- "Medicare Remit Easy Print Software" Fact Sheet — Revised
- "Mass Immunizers and Roster Billing" Fact Sheet — Revised
- "Medicare Preventive Services" Educational Tool — Reminder
- "Medicare Basics Commonly Used Acronyms" Educational Tool — Reminder
- Medicare Learning Network Product Available In Electronic Publication Format
- Upgraded Learning Management System — Coming Soon

MLN Connects Provider eNews Special Edition – July 8, 2015

CMS Begins Implementation of Key Payment Legislation

Proposed Update to Physician Fee Schedule is First Since Repeal of SGR

On July 8, CMS released the first proposed update to the physician payment schedule since the repeal of the Sustainable Growth Rate through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The proposal includes a number of provisions focused on person-centered care, and continues the Administration's commitment to transform the Medicare program to a system based on quality and healthy outcomes.

"CMS is building on the important work of Congress to shift the Medicare program toward a system that rewards physicians for providing high quality care," said Andy Slavitt, Administrator of CMS. "Thanks to the recent landmark Medicare and children's health insurance program legislation, CMS and Congress are working together to achieve a better Medicare payment system for physicians and the American people."

In the proposed CY 2016 Physician Fee Schedule rule, CMS is also seeking comment from the public on implementation of certain provisions of the MACRA, including the new Merit-based Incentive payment system (MIPS). This is part of a broader effort at the Department to move the Medicare program to a health care system focused on the delivery of quality care and value.

The proposed rule includes updates to payment policies, proposals to implement statutory adjustments to physician payments based on misvalued codes, updates to the Physician Quality Reporting System, which measures the quality performance of physicians participating in Medicare, and updates to the Physician Value-Based Payment Modifier, which ties a portion of physician payments to performance on measures of quality and cost. CMS is also seeking comment on the potential expansion of the Comprehensive Primary Care Initiative, a CMS Innovation Center initiative designed to improve the coordination of care for Medicare beneficiaries.

The proposed rule also seeks comment on a proposal that supports patient- and family-centered care for seniors and other Medicare beneficiaries by enabling them to discuss advance care planning with their providers. The proposal follows the American Medical Association's recommendation to make advance care planning services a separately payable service under Medicare.

The release of the rule triggers a 60-day comment period, during which time CMS welcomes the input of stakeholders and the public. A final rule will be published this fall.

For More Information:

- Proposed Rule
- Fact Sheet

MLN Connects Provider eNews – July 9, 2015

MLN Connects® Provider eNews for July 9, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10
- MLN Connects National Provider Call: Countdown to ICD-10
- "ICD-10 Website Wheel" Educational Tool — Released
- "Medicare FFS Claims Processing Guidance for Implementing ICD-10 — A Re-Issue of MM7492" MLN Matters® Article — Revised
- Medicare Learning Network ICD-10 Products Available In Electronic Publication Format
- Get Ready for ICD-10 with the CMS Infographic
- ICD-10 Resources for Medicare Providers

MLN Connects® National Provider Calls and Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool Webcast — Last Chance to Register
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs Call — Last Chance to Register
- ESRD QIP: Proposed Rule for Payment Year 2019 Call — Register Now
- Check Out the MLN Connects Call Program Collection of Provider Resources

CMS Events

- PERM Cycle 1 Provider Education Sessions

Announcements

- Proposed Hospital Outpatient and ASC Policy and Payment Changes for 2016, including Two-Midnight Rule
- New Initiative to Promote Value-Based Home Health Care
- PV-PQRS Users: Do Not Log into the Portal until Further Notice
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- EHR Incentive Programs: Reporting CQMs with a Zero Numerator and/or Denominator

MLN Connects Provider eNews – July 16, 2015

MLN Connects® Provider eNews for July 16, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10
- Claims that Span the ICD-10 Implementation Date

MLN Connects® National Provider Calls and Events

- ESRD QIP: Proposed Rule for Payment Year 2019 Call — Register Now
- Hospital Compare Overall Star Ratings Methodology Call — Registration Now Open

CMS Events

- PERM Cycle 1 Provider Education Session

Announcements

- World Hepatitis Day — Medicare Coverage for Viral Hepatitis
- CMS Cutting-Edge Technology Identifies and Prevents $820 Million in Improper Medicare Payments in First Three Years
- Comprehensive Care for Joint Replacement
- PV-PQRS Users: Set up Your EIDM Account
- Home Health Agencies to Receive PEPPER
- CMS to Release a Comparative Billing Report on CT of the Abdomen and Pelvis in August
- eCQM: 2015 QRDA Implementation Guide Addendum Available
- Quarterly Provider Update for July 2015

Medicare Learning Network® Educational Products

- Medicare Learning Network Products Available in Electronic Publication Format
- Upgraded Learning Management and Product Ordering System — Important Updates

MLN Connects Provider eNews – July 23, 2015

MLN Connects® Provider eNews for July 23, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- ICD-10 Is Less than 70 Days Away: Get Ready
- Are Non-HIPPA Covered Entities Required to Transition to ICD-10?
- MLN Connects National Provider Call: Countdown to ICD-10
- Video: 10 Facts about ICD-10

MLN Connects® National Provider Calls and Events

- ESRD QIP: Proposed Rule for Payment Year 2019 Call — Last Chance to Register
- Proposed Reform of Requirements for Long-Term Care Facilities Call — Registration Now Open
- Hospital Compare Overall Star Ratings Methodology Call — Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts
- Associations and Organizations Providing Credit for MLN Connects Events

Announcements

- CMS Releases First Round of Home Health Compare Quality of Patient Care Star Ratings
- CMS Announces Medicare Care Choices Model Awards
- LTCH QRP Data Submission Deadline: August 15
- IRF QRP Data Submission Deadline: August 15
- Updated Open Payments CME Guidance
- eCQM: 2016 QRDA Implementation Guide Now Available

Claims, Pricers, and Codes

- July 2015 OPPS Pricer File Update

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 4]" Educational Tool — Released
- "Home Oxygen Therapy" Booklet — Released
- "The Basics of DMEPOS Accreditation" Fact Sheet — Revised
- "Medical Privacy of Protected Health Information" Fact Sheet — Reminder
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course — Reminder
- Medicare Learning Network Products Available In Electronic Publication Format
- New Continuing Education Organization Now Accepting Medicare Learning Network Web-Based Training Courses

MLN Connects Provider eNews – July 30, 2015

MLN Connects® Provider eNews for July 30, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
- MLN Connects National Provider Call: Countdown to ICD-10
- List of Valid ICD-10-CM Codes
- Use of Unspecified Codes in ICD-10-CM
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health

- Claims that Span the ICD-10 Implementation Date

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call — Register Now
- Hospital Compare Overall Star Ratings Methodology Call — Register Now
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- On Its 50th Anniversary, More than 55 Million Americans Covered by Medicare
- Temporary Moratoria Extended on Enrollment of Home Health Agencies and Ambulance Suppliers
- eCQM: Version 2 Schematron Rules for 2016 QRDA Implementation Guide Now Available

Medicare Learning Network® Educational Products

- July 2015 Version of the Medicare Learning Network Catalog — Released
- "Medicare Claim Review Programs" Booklet — Revised
- Medicare Learning Network Products Available in Electronic Publication Format
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects Provider eNews – August 6, 2015

MLN Connects® Provider eNews for August 06, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities — Update
- MLN Connects National Provider Call: Countdown to ICD-10
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call — Last Chance to Register
- Hospital Compare Overall Star Ratings Methodology Call — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
- New MLN Connects National Provider Event Audio Recording and Transcript

MLN Connects Videos

- New Videos on HIS Manual for Hospice Quality Reporting Program

Announcements

- Inpatient and Long-term Care Hospital PPS: Final FY 2016 Payment and Policy Changes
- Skilled Nursing Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Rehabilitation Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2016 Payment and Policy Changes
- Hospice: Final FY 2016 Payment Rates
- Immunizations – Not Just for Kids

- Technical Correction to ESRD PPS Proposed Rule
- Decision Memorandum and Revised Scope of Benefit NCD for Speech Generating Devices
- Hospice Providers: Review HIS Reports to Confirm Successful Submission
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs, and PHPs
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: Determine Broadband Speed in Your Area

Claims, Pricers, and Codes

- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System — Going Live August 12
- "HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules" Fact Sheet — Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article — Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects Provider eNews Special Edition – August 11, 2015

DMEPOS Competitive Bidding: Timeline for Round 1 2017

CMS has announced the bidding timeline for Round 1 2017 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

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

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. The CBIC Round I 2017 web page features helpful information for suppliers, including bidding rules, user guides, fact sheets, checklists, and bid preparation worksheets. Subscribe to receive CBIC email updates about registration and bidding.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free at 877-577-5331 Monday through Friday 9am – 7pm prevailing ET. Hours are extended to 9pm prevailing ET during the last two weeks of the registration and bidding windows.

For More Information:

- Press Release
- Fact Sheet

MLN Connects Provider eNews – August 13, 2015

MLN Connects® Provider eNews for August 13, 2015
View this edition as a PDF

In This Edition:

Editor's Note:

Your responses to our eNews feedback tool help us improve our service. Each week, we offer an online version of the eNews, as well as a PDF version, located below the table of contents on the web page. If you are having trouble viewing the eNews, please let us know through our updated feedback tool.

If you have a question about Medicare, please contact your Medicare Administrative Contractor.

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10
- Finding ICD-10 Information Online Just Got Easier
- 5 Ways to Check Your Claim Status
- Home Health Episodes that Span October 1, 2015
- New CMS Infographic: Get the Facts About ICD-10

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- New MLN Connects National Provider Event Audio Recording and Transcript

Announcements

- DMEPOS Competitive Bidding: Timeline for Round 1 2017

Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System — Now Live

MLN Connects Provider eNews – August 20, 2015

MLN Connects® Provider eNews for August 20, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10 — Last Chance to Register
- Use of Unspecified Codes in ICD-10-CM
- List of Valid ICD-10-CM Codes
- ICD-10 Clinical Concepts Guides for Specialties

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast — Register Now

CMS Events

- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis for Referring Providers
- Hospital Quality Reporting Program Webinars: Impact of FY 2016 Payment Rule

- Hospital Quality Reporting Webinar Series: Early Management Bundle, Severe Sepsis/Septic Shock

Announcements

- Additional Participants in Pilot Project to Improve Care and Reduce Costs for Medicare
- CMS Implements Changes in its Medical Review Education and Enforcement Strategies
- ESRD QIP PY 2016 Preview Period Extended
- Get Ready for DMEPOS Competitive Bidding

Claims, Pricers, and Codes

- Claims Hold for Diabetic Test Strips and Other Supply Items

Medicare Learning Network® Educational Products

- "National Site Visit Verification (NSV) Initiative" MLN Matters Article — Released
- "Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims" MLN Matters Article — Released
- "PECOS Technical Assistance Contact Information" Fact Sheet — Revised

MLN Connects Provider eNews Special Edition – August 25, 2015

Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding

Authorized Officials Should Register Now

Registration is now open to all suppliers interested in participating in Round 1 2017 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to submit a bid, you are required to register in CMS' ***Enterprise Identity Management (EIDM)*** system to obtain a user ID and password to access the online DMEPOS bidding system (DBidS).

Designate one individual listed as an authorized official (AO) on your organization's CMS-855S enrollment application in the Provider Enrollment, Chain and Ownership System (PECOS) to act as your AO for registration purposes. The AO must be the first person in the organization to register in EIDM. After an AO successfully registers, other individuals listed as an AO on the CMS-855S in PECOS may register as back-up authorized officials (BAOs). The AO must approve a BAO's request to register. For the AO and BAOs to register successfully, the name and Social Security number entered in EIDM must match exactly with what is recorded on the CMS-855S and on file in PECOS. Individuals not listed as an AO on the CMS-855S in PECOS may only register to serve as end users (EUs). The AO or a BAO must approve an EU's request to register. Bidders are prohibited from sharing user IDs and passwords.

We strongly urge all AOs to register no later than September 21, 2015, to ensure that BAOs and EUs have time to register. We recommend that BAOs register no later than October 19, 2015, so that they will be able to assist AOs with approving EU registration before bidding begins on October 15, 2015.

Registration has been extended and will close on Friday, November 20, 2015, at 9pm prevailing ET – ***no AOs, BAOs, or EUs can register after registration closes. You will not be able to bid if you do not register on time. Bidding will close on Wednesday, December 16, 2015.***

Register by clicking on ***REGISTRATION IS OPEN*** above the Registration clock on the Competitive Bidding Implementation Contractor (CBIC) website. We strongly recommend that you review the EIDM Reference Guide and EIDM: Getting Started Registration Checklist.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for "E-mail Updates" on the home page of the CBIC website. For information about Round 1 2017, please refer to the bidder education materials located under "Bidding Suppliers" on the CBIC Round 1 2017 web page. The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the ***Educational Information*** section of the Round 1 2017 page.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 877-577-5331. During registration and bidding periods, the customer service center will be open between 9am - 7pm prevailing ET, Monday through Friday. Hours are extended to 9pm prevailing ET during the last two weeks of the registration and bidding windows.

MLN Connects Provider eNews – August 27, 2015

MLN Connects® Provider eNews for August 27, 2015
View this edition as a PDF

In This Edition:

Countdown to ICD-10

- Get ICD-10 Answers in One Place
- ICD-10 Resources
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Claims that Span the ICD-10 Implementation Date
- ICD-10-CM POA Exempt Codes for FY 2016 Available
- MS-DRG Grouper and MCE Software Available
- Video Slideshow from June 18 MLN Connects ICD-10 Call Available

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast — Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recordings and Transcripts

Other CMS Events

- PQRS Webinars: Public Reporting of 2014 Measures

Announcements

- Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings
- Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding

Medicare Learning Network® Educational Products

- "Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects Provider eNews Special Edition – August 27, 2015

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

From July 20 through 24, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in a third successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

This final end-to-end testing week demonstrated that CMS systems are ready to accept and process ICD-10 claims. Approximately 1,200 providers and billing companies participated, and testers submitted over

29,000 test claims. View the results.

Overall, participants in the July end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. The acceptance rate for July was similar to the rates in January and April, but with an increase in the number of testers and test claims submitted. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

Through its robust system release testing, CMS has ensured that the Medicare FFS claims processing systems changes for ICD-10 implementation have been thoroughly tested and validated. CMS also has conducted an unprecedented additional level of testing to help providers prepare for ICD-10. This was the final end-to-end testing week, but providers are encouraged to participate in acknowledgement testing, which can be completed at any time prior to the implementation date.

Be Prepared

Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015; or accept claims that contain both ICD-9 and ICD-10 codes.

CMS has created a number of ICD-10 tools and resources for providers. One tool is the "Road to 10," aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation.

For more information, visit the Medicare FFS Provider Resources web page.

Redeterminations and Reconsiderations of Certain Claims – Limiting the Scope of Review

MLN Matters® Number: SE1521

Provider Types Affected

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

What You Need to Know

This Special Edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and Qualified Independent Contractors (QICs) regarding the scope of review for redeterminations (Technical Direction Letter-150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after August 1, 2015, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a post-payment review or audit, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a Zone Program Integrity Contractor (ZPIC), Recovery Auditor, MAC, or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. If an appeal involves a claim or line item denied on a pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or Correct Coding Initiative edits) will result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC **on or after August 1, 2015.** It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

Additional Information

You can find out more about appealing claims decisions in the "Medicare Claims Processing Manual" (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), Section 310.4.C.1. (Conducting the Redetermination (Overview)) at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf on the CMS website.

You can also find out more about 1) conducting a redeterminations in 42 CFR 405.948, at http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc 15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948; and 2) conducting a reconsideration in 42 CFR 405.968 at http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968 on the Internet.

Telephone Reopenings: Resources for Success

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

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

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

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

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

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

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

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

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.

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.

DMEPOS Fee Schedule Code Set - October 2015 Quarterly Update

MLN Matters® Number: MM9279
Related CR Release Date: August 14, 2015
Related Transmittal #: R3323CP
Change Request (CR) #: CR 9279
Effective Date: January 1, 2015 (for implementation of fee schedule amounts for codes in effect on January 1, 2015; October 1, 2015 for all other changes)
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9279 alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2015. Make sure your billing staffs are aware of the changes.

Background

The DMEPOS fee schedule 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 Pub.100-04, "Medicare Claims Processing Manual," Chapter 23, Section 60, found here http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

The recurring update notification provides instructions regarding the October quarterly update for the 2015 DMEPOS fee schedule. Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for Parenteral and Enteral Nutrition (PEN), splints and casts, and Intraocular Lenses (IOLs) inserted in a physician's office.

As part of the October 2015 update, fee schedules are established for the following two Healthcare Common Procedure Coding System (HCPCS) codes added to the HCPCS file effective January 1, 2005:

- E0639 - Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories, and
- E0640 - Patient lift, fixed system includes all components/accessories.

The fee schedule amounts for both codes were established using fees for comparable items in accordance with the instructions found in the "Medicare Claims Processing Manual," Chapter 23, Section 60.3. An average of the existing hydraulic or mechanical patient lift code E0630 and the electric patient code E0635 were used to establish the fee schedules for the hydraulic or electric patient lifts described under E0639 and E0640. The fee schedules for E0639 and E0640 are effective for dates of service on or after January 1, 2015. This update also revises the type of service code for HCPCS codes E0639 and E0640 from "9" to type of service code "R".

CR9279 also provides revised fee schedules for speech generating device (SGD) HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 per the recent amendments to Section 1834(a)(2)(A) of the Social Security Act. The Steve Gleason Act of 2015 was signed by the President on July 30, 2015 and changes the DME payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015 and September 30, 2018, from capped rental (CR) to inexpensive or routinely purchased (IN). Instructions relating to the implementation of the SGD amendments to Section 1834(a)(2)(A) were issued in Change Request 9179, dated June 12, 2015. The NU, UE, and RR fee schedule amounts for codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 are being added to the fee schedule file as part of this update.

The MLN Matters® Article related to CR9179 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9179.pdf on the CMS website.

Additional Information

The official instruction, CR9279, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3323CP.pdf on the CMS website.

HCPCS Drug/Biological Code Changes - October 2015 Quarterly Update

MLN Matters® Number: MM9273
Related Change Request (CR) #: CR 9273
Related CR Release Date: August 6, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3304CP
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9273 informs the MACs that, effective for claims with dates of service on or after October 1, 2015, new Healthcare Common Procedure Coding System (HCPCS) code Q9979 (INJECTION, ALEMTUZUMAB, 1 MG) will be payable for Medicare. Make sure that your billing staff are aware of these changes.

Background

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. Change Request (CR) 9273 instructs that, effective for claims with dates of service on or after October 1, 2015, HCPCS code Q9979 will be established for alemtuzumab (Lemtrada) and will be payable for Medicare. See the following table for details regarding this temporary HCPCS code:

HCPCS Code	Short Description	Long Description	Type of Service (TOS) Code	Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator
Q9979	Injection, Alemtuzumab	Injection, Alemtuzumab, 1 mg	1, P	E

Additional Information

The official instruction, CR 9273, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3304CP.pdf on the CMS website.

HIPAA Version 5010 Claims - Non-Specific Procedure Code Description Requirements – Second Revision

MLN Matters® Number: SE1138 Revised

This article was revised on June 22, 2015, to delete the last two sentences of the "Background" section on page 2. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required. Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

Background

The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: "Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name". If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional Information

For 5010/D.O implementation information and deadlines, refer to MLN Matters® Special Edition Article #SE1131, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf on the CMS website.

If you are not ready, consider contacting your Medicare contractor to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/index.html?redirect=/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, Change Request (CR) 7392, "Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates," dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

HPTCs - October 2015 Update

MLN Matters® Number: MM9260
Related CR Release Date: August 21, 2015
Related Transmittal #: R3336CP
Change Request (CR) #: 9260
Effective Date: October 1, 2015
Implementation Date: January 4, 2016 - Contractors with the capability to do so shall implement this CR effective October 1, 2015.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9260 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

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

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

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and

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

CR 9260 implements the NUCC HPTC code set that is effective on October 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

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

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

Additional Information

The official instruction, CR issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3336CP.pdf on the CMS website.

New and Revised POS Codes for Outpatient Hospitals

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

Provider Types Affected

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

Provider Action Needed

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

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

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

Background

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

The POS code set provides care-setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for code specificity than Medicare, and many of the past years' new codes that have been developed to meet Medicaid's needs.

While Medicare does not always need this greater specificity in order to appropriately pay claims; it nevertheless adjudicates claims with the new codes to ease coordination of benefits, and to give Medicaid and other payers the setting information that they require. Therefore, as a payer, Medicare must be able to recognize any valid code from the POS code set that appears on the HIPAA standard claim transaction.

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

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

New and Revised POS Codes Effective January 1, 2016

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

CR9231 also:

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

Additional Information Related to POS Codes 19 and 22

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

Additional Information

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

Quarterly HCPCS Drug/Biological Code Changes – July 2015 Update – Second Revision

MLN Matters® Number: MM9167 Revised
Related Change Request (CR) #: CR 9167
Related CR Release Date: July 10, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3292CP
Implementation Date: July 6, 2015

This article was revised on July 20, to reflect the revised CR9167 issued on July 10. In the article, language has been modified to clarify the use of Q9977. Also, the CR release date, transmittal number, and the Web address for accessing CR9167 are revised. On July 22, 2015, the article was revised further to include additional language from the revised CR9167. This additional language is in the note box on page 3 of this article. All other information remains the same.

Provider Types Affected

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

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

Effective for Claims with Dates of Service on or after:	HCPCS Code	Long Description	Short Description	Type of Service (TOS)
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

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 address the use of a compounded drug NOC code on claims for compounded drugs.

The new compounded drug code, Q9977 - Compounded Drug, Not Otherwise Classified, is not a replacement for existing codes. It is intended to distinguish compounded drugs (which may include biologicals) from other "not otherwise classified" codes such as J3490, J3590, J7799, J9999 and existing specific codes for compounded nebulized drugs. The implementation of Q9977 as a means of identifying compounded drug claims does not affect existing payment policy for compounded drugs as outlined in the "Medicare Claims Processing Manual," Chapter 17, Section 20.1.2..

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/R3292CP.pdf on the CMS website.

Competitively-Bid Wheelchair Accessories Furnished with Non-Competitively Bid Wheelchair Base Equipment - Clarification of the Policy

MLN Matters® Number: MM9272
Related Change Request (CR) #: CR 9272
Related CR Release Date: August 14, 2015
Effective Date: July 1, 2013
Related CR Transmittal #: R3324CP
Implementation: January 4, 2016

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for competitively-bid wheelchair accessories furnished with non-competitively bid wheelchair base equipment provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9272 as a clarification regarding CMS claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in competitive bidding areas (CBAs). As a result of this clarification, you may need to resubmit certain claims that Medicare previously denied. See the Background section of this article for more detailed information on the claims you may need to resubmit.

Background

The Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173). This publication amended section 1847 of the Social Security Act (the Act) to require the Secretary to establish and implement programs under which CBAs are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

Currently, if a supplier submits an unassigned claim for a competitively bid accessory (identified by a Healthcare Common Procedural Coding System (HCPCS) code) that is used on a non-competitively bid base, the claim is denied because Competitive Bidding Program editing in the shared systems requires claims with CBP items to be assigned. This CR9272 adjusts that process.

With CR9272, the "Medicare Claims Processing Manual," Chapter 36, Competitive Bidding, Section 50.16 "Exception for Wheelchair Accessories Furnished with Non-Competitively Bid Wheelchair Base Equipment" is revised to state that effective for claims with dates of service on or after July 1, 2013, competitively bid wheelchair accessories are paid in accordance with standard Medicare DMEPOS payment rules, not competitive bidding rules, when furnished with non-competitively bid wheelchair base equipment (see CR 8864, Transmittal 1420, issued on August 15, 2014, for applicable HCPCS codes). (To review MLN Matters® Article 8864, you may visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8864.pdf on the CMS website.)

Medicare will allow an unassigned claim under the following conditions:

- The item is a competitively bid wheelchair accessory that is used with a non-competitively bid wheelchair base; AND
- The KY modifier is submitted with the claim.

Your DME MAC will reprocess claims that were either incorrectly paid or denied in error for dates of service between the effective date, July 1, 2013, and implementation date of CR9272 when you resubmit such claims within 6 months from the implementation of CR9272. Your DME MAC will override the timely filing edits for these resubmitted claims.

Suppliers that billed directly to the beneficiary and received payment for these claims must resubmit and give beneficiaries the applicable overpayments.

Additional Information

The official instruction, CR 9272, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3324CP.pdf on the CMS website.

DMEPOS CBP – Quarterly Update October 2015

MLN Matters® Number: MM9244
Related Change Request (CR) #: CR 9244
Related CR Release Date: August 6, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3308CP
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9244 to provide the DMEPOS, Competitive Bidding Program (CBP) October, 2015, quarterly update. CR9244 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 on the left of the page.

Background

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

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

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

Additional Information

The official instruction, CR 9244 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3308CP.pdf on the CMS website.

COMPETITIVE BID

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.

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

DMEPOS Competitive Bidding Announcement: Non-invasive Pressure Support Ventilators Removed from Round 1 2017

CMS has removed the non-invasive pressure support ventilators product category from Round 1 2017 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. For additional information, go to the HCPCS Decision Regarding Codes for Ventilators.

COVERAGE

SGD - Pub. 100-03, NCD Manual, Chapter 1, Part 1, Section 50.1

MLN Matters® Number: MM9281
Related Change Request (CR) #: CR 9281
Related CR Release Date: August 21, 2015
Effective Date: July 29, 2015
Related CR Transmittal #: R184NCD
Implementation Date: September 21, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9281 updates the Medicare "National Coverage Determinations Manual" to add a revised scope of benefit National Coverage Determination (NCD) for Speech Generating Devices (SGDs) covered under the Medicare benefit category for Durable Medical Equipment (DME). Please make sure that your billing staff are aware of these changes.

Background

Key information in the revised NCD in Chapter 1 of the Manual is as follows:

SGDs are considered to fall within the Durable Medical Equipment (DME) benefit category established by Section 1861(n) of the Social Security Act. They are covered for patients who suffer from a severe speech impairment and have a medical condition that warrants the use of a device based on the following definitions.

SGDs are defined as DME that provide an individual who has a severe speech impairment with the ability to meet his or her functional, speaking needs. Speech Generating Devices are devices or software that generate speech and are used solely by the individual who has a severe speech impairment. The speech is generated using one of the following methods:

- digitized audible/verbal speech output, using prerecorded messages;
- synthesized audible/verbal speech output which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;

- synthesized audible/verbal speech output which permits multiple methods of message formulation and multiple methods of device access; or
- software that allows a computer or other electronic device to generate audible/verbal speech.

Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to "speak" or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

If an SGD is limited to use by a patient with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for the device to be dedicated only to audible/verbal speech output to be considered DME. Computers and tablets are generally not considered DME because they are useful in the absence of an illness or injury.

Nationally Non-Covered Indications

Internet or phone services or any modification to a patient's home to allow use of the SGD are not covered by Medicare because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of an SGD that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not covered. This would include any computing hardware or software not necessary to allow for generation of speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly related to meeting the functional speaking communication needs of the patient, including video communications or conferencing. These features of a speech generating device do not fall within the scope of Section 1861(n) of the Social Security Act and the cost of these features are the responsibility of the beneficiary. Suppliers of SGDs are encouraged to furnish the beneficiary with a voluntary Advance Beneficiary Notice (ABN) which informs that these features are not covered by Medicare and the beneficiary is liable for the expense of these features.

Other

MACs acting within their respective jurisdictions have discretion to cover or not cover speech generating devices based on their individual reasonable and necessary determinations.

Additional Information

The official instruction, CR9281, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R184NCD.pdf on the CMS website. The revised portion of the NCD Manual is part of CR9281.

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

Joint DME MAC Publication

This is a revision to previous version published on December 18, 2014.

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

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

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

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

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

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

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

Claims for HYQVIA must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:

- Name of Drug
- Manufacturer name
- Dosage Strength
- Manufacturer's Suggested retail price (MSRP)

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

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

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

PDAC Code Review – E0740 Non-Implantable Pelvic Floor Electrical Stimulator

DME MAC Joint Publication

The Pricing, Data, Analysis and Coding Contractor (PDAC) recently evaluated HCPCS code E0740 (INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONITOR, SENSOR AND/OR TRAINER) and discovered two differing product types on the Product List: (1) pelvic floor muscle electrical stimulators, and (2) pelvic floor muscle monitoring devices. The PDAC reviewed the history of the code to determine which product type E0740 was intended to describe.

Code E0740 History
During the 1980's E0740 was used to describe a battery used in a TENS device. In 1988 the code was discontinued. In 1995, the CMS HCPCS Workgroup reassigned the code as:

> E0740 (INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONITOR, SENSOR AND/OR TRAINER).

This reassigned code narrative was effective for use January 1, 1995.

CMS concurrently published a National Coverage Determination (NCD 230.8) for pelvic floor electrical stimulators. The NCD says:

> **230.8 - Non-Implantable Pelvic Floor Electrical Stimulator**
>
> Non-implantable pelvic floor electrical stimulators provide neuromuscular electrical stimulation through the pelvic floor with the intent of strengthening and exercising pelvic floor musculature. Stimulation is generally delivered by vaginal or anal probes connected to an external pulse generator.
>
> The methods of pelvic floor electrical stimulation vary in location, stimulus frequency (Hz), stimulus intensity or amplitude (mA), pulse duration (duty cycle), treatments per day, number of treatment days per week, length of time for each treatment session, overall time period for device use and between clinic and home settings. In general, the stimulus frequency and other parameters are chosen based on the patient's clinical diagnosis.
>
> Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.
>
> A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Part of the code history assessment is to identify what product were initially included in E0740 when the revised code narrative was assigned in 1995. CMS Alpha-Numeric Workgroup applications from 1995 were reviewed to determine the predicate product(s) used to establish HCPCS code E0740. A predicate product is the item(s) used as the index product in the establishment of the original HCPCS code and is the exemplar to which other products are compared when assessing code assignment. The three predicate products used for code E0740 in 1995 were:

- Perry Vaginal (Self-Regulation Systems, Inc.)
- Perry Anal (Self-Regulation Systems, Inc.)
- Innova ™ Feminine Incontinence Treatment System (Empi, Inc.)

All of these products are non-implantable pelvic floor electrical stimulation devices with muscle contraction monitoring capability included.

Coding Determination

Based upon the code narrative, code history including the predicate products, and creation of National Coverage Determination 230.8, the PDAC concluded that HCPCS code E0740 is intended to describe non-implantable pelvic floor electrical stimulators with integrated monitoring capabilities. Devices limited to only muscle monitoring capability (i.e., without electrical muscle stimulation capability) were not intended to be included in E0740.

Product Review

Products that only have monitoring capabilities but do not include electrical stimulation of the pelvic floor muscles have been assigned to E0740. All products currently listed on the PDAC Product Classification List with HCPCS code E0740 will undergo a code re-review. Manufacturers of affected products will be notified to submit product information to the PDAC to take into consideration along with the product information already on file.

Coding for Monitoring Devices

In general, Medicare does not provide reimbursement for devices used to provide monitoring functions. There may be some Part B coverage for devices used as part of biofeedback therapy. Biofeedback therapy does not fall within DME contractor jurisdiction. Consult the appropriate A/B MAC for information regarding coverage and coding for devices used for biofeedback therapy. Coding for products that fall within DME contractor jurisdiction will be assigned as part of the coding review process.

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

COVERAGE

Surgical Dressings - Draft Policy Released for Comment

The comment period for the Surgical Dressings Draft Local Coverage Determination (LCD) begins on Thursday, August 6, 2015, and ends at Close of Business (COB) on Monday, September 21, 2015. This policy is available on the Draft LCDs page.

DOCUMENTATION

Physician Documentation Responsibilities

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

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

Physician Education Resources

Noridian Provider Outreach and Education has compiled a list of resources for suppliers to use for physician education. Noridian encourages suppliers to utilize these resources as tools when working with referral sources. For complete information, see the Physician Resource Letters page of the Noridian website.

Affordable Care Act (ACA) 6407 – Supplier Frequently Asked Questions (FAQs)

Joint DME MAC Article

Due to the high volume of inquiries regarding ACA 6407 requirements, the DME MAC Provider Outreach Departments developed a "Supplier Frequently Asked Questions" document.

ACA 6407

Q: What is ACA 6407?

A: "ACA" refers to the Affordable Care Act and "6407" is the specific section of the Act containing details of certain HCPCS codes which require a face-to-face (F2F) encounter with a physician and a valid, written order prior to delivery (WOPD). Suppliers should review the DME MAC Joint Publication titled "Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act – Revised" for a complete list of affected HCPCS codes.

Q: When will CMS enforce the F2F requirements and WOPD?

A: Section 6407 of the ACA was implemented on July 1, 2013, and the DME MAC contractors began enforcement of the WOPD and National Provider Identifier (NPI) requirements for dates of services on or after January 1, 2014. Enforcement by the DME MACs, of the F2F requirement, has been postponed by CMS until a future date.

Q: What is the difference between "implementation" and "enforcement" regarding ACA 6407?

A: Implementation is the date that the provisions of ACA 6407 became effective (July 1, 2013). Enforcement is when DME MACs begin auditing claims to determine that suppliers are following the provisions of ACA 6407.

Q: Is the Comprehensive Error Rate Testing (CERT) contractor recognizing the delay in the enforcement of the F2F requirements?

A: No. CERT has not been instructed by CMS to delay the enforcement of the F2F requirements; therefore, claims reviewed by the CERT contractor that are not compliant with the F2F requirements may result in denial or recoupment. If the CERT contractor denies for this reason, suppliers may submit a request for a redetermination.

Face-to-Face Encounter

Q: Do suppliers need to obtain a new F2F encounter every six months?

A: No, there is no requirement under ACA 6407 that a supplier obtain documentation of a new F2F encounter on a periodic basis. A F2F encounter within six months prior to the prescription date is required for any order obtained on or after July 1, 2013.

Q: What if the policy has a requirement for a F2F encounter within 30-days for an item that is also on the ACA list? Must the F2F encounter be performed within the 30-days or within six months?

A: If the Local Coverage Determination (LCD) requires that a F2F encounter must be performed within 30-days then that requirement must still be met. The ACA F2F requirement does not replace any existing LCD timing requirements for F2F encounters. Suppliers must meet both the ACA requirements and any requirements outlined in the applicable LCD. In this example, by meeting the LCD requirement, the ACA requirement is automatically met.

Q: Does the ACA F2F requirement apply to orthotics and prosthetics?

A: No. ACA 6407 applies to certain DME HCPCS only. Suppliers should review the DME MAC Joint Publication titled "Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act – Revised" for a complete list of affected HCPCS codes.

Q: Must the F2F encounter specifically mention the DME item being ordered?

A: No. However, in order for the ACA requirements to be met, the F2F encounter must address a medical condition that supports the item ordered.

Q: Does the F2F encounter with the physician need to specifically state the beneficiary was there for a F2F encounter for the specific DME item, or can the beneficiary have a visit and the physician's notes show physical limitations that justify the specific DME item?

A: In contrast to power mobility devices, items encompassed by the ACA 6407 requirements do not require that the F2F encounter specify that the visit was expressly for the purpose of documenting the need for the specific item of DME. However, as noted above, there must be sufficient documentation in the medical records to support the need for the item ordered.

Q: Can the F2F documentation be electronically signed by the physician?

A: CMS has published instructions to contractors allowing electronic signatures. CMS has not provided detailed guidance defining the format or contents of an electronic signature. CMS does allow contractors to authenticate electronic signatures. We recommend that when suppliers obtain electronic records that the electronic signatures are clearly identifiable and provide comparable information as is required for a non-electronic signature for the same document type. Refer to each LCD and the Supplier Manual for additional information regarding signatures.

Written Orders Prior to Delivery/Face-to-Face

Q: What elements must be included on a WOPD for an item(s) associated with ACA F2F HCPCS code list?

A: The WOPD must include all required elements for a standard detailed written order and additionally must include the prescribing practitioner's NPI number. The elements would need to include:

- Beneficiary's name
- Physician's name
- Date of the order and the start date if start date is different from the date of the order
- Detailed description of the item(s)
- **The prescribing practitioner's NPI**

- The signature of the ordering practitioner
- Signature date

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

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

Q: Can the WOPD and the F2F encounter be on the same document as long as it is in the medical record?

A: No. The F2F encounter and order must be two separate documents. The F2F must be incorporated into the medical record and the order would need to be a separate document from the medical record.

Q: If the beneficiary is in the hospital, can the attending physician conduct the F2F encounter and the beneficiary's primary care physician complete the WOPD?

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

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

Q: Can the F2F encounter, WOPD and the delivery of the DME item all be completed in the same day?

A: Yes. However, the date stamp (or similar) indicating the date of receipt of the documents must clearly reflect that the F2F and WOPD were received prior to delivery of the item.

Documenting a Receipt Date

Q: Must the F2F encounter and WOPD be date stamped by the supplier upon receipt?

A: A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the F2F encounter and the completed WOPD with the prescribing physician's signature and a signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Q: Does every page of the F2F encounter need to be date stamped?

A: As long as it is clear that the record includes all pages, a single date stamp or similar is sufficient. When submitting the documentation for review, all pages need to be submitted to support the date stamp or similar.

Q: What methods are acceptable for documenting a receipt date?

A: The DME MACs do not specify what method may be used to indicate date of receipt; however, there must be some indicator or notation on the documents that they were received by the supplier within the required time period. Some commonly accepted methods are:

- Hardcopy date stamps
- Hand-written dates

- Facsimile headers and electronic receipt dates (see question below for additional information)

Regardless of the method used, it must be clear to contractor staff reviewing the claim that the date received meets the requirements in the applicable LCD.

Q: Can a fax header be used to document receipt of the WOPD and the F2F encounter prior to delivery or must we use a date stamp?

A: We highly recommend the use of a date stamp to document receipt of the WOPD and F2F. If a fax date or equivalent is used, the information must be legible, it must be clear that the supplier is the one that received the order and F2F on the date listed. Possible ways to document this would be to also submit a copy of the fax cover sheet or the header listing the "to" and "from" sender names.

Written Order Prior to Delivery - Corrections to Document

Q: What happens if there is an error on the WOPD or the F2F document and it is not noticed until after the equipment is delivered to the beneficiary?

A: WOPD is a long-standing statutory requirement for certain items of DME. The list of items subject to WOPD was expanded by the Affordable Care Act Section 6407. Medicare policy stipulates that a WOPD that is missing an element is not "curable" by a provider (i.e., a provider cannot make corrections to a WOPD) except as outlined below.

If errors in the WOPD are found ***prior*** to delivery, the supplier has two options:

- The WOPD may be properly amended following the guidance in the Internet-Only Manual (IOM), Publication 100-08, ***Medicare Program Integrity Manual*** , Chapter 3, Section 3.3.2.5; or,
- A new WOPD may be created and sent to the physician for signature and date.

If errors in the WOPD are found after delivery of the item, the supplier has two options:

- If the error is discovered prior to claim submission, the original supplier may recover the delivered item(s), obtain a compliant, complete WOPD and then may redeliver the item(s) to the beneficiary; or,
- If the error is discovered after submitting a claim, the original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements.

Because WOPD is a statutory requirement, claims denied because of a defective WOPD result in a beneficiary liability determination. Suppliers are strongly encouraged to review their WOPD documentation carefully ***prior to*** delivery to ensure that all the requirement elements are present on the document.

Q: **Does Medicare consider a different location (with a different NPI or Provider Transaction Access Number (PTAN)) another supplier?**

A: Yes. A different location of the same company is considered a "new" supplier as that location operates and bills the Medicare program under a separate NPI/PTAN.

Resource Content

- MM8304
- Medicare Program Integrity Manual(Internet-Only Manual, Publication 100-08), Chapter 3, Section 3.3.2.5

Joint DME MAC Articles

- Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act – Revised
- ACA 6407 Requirements – Corrections and Amendments To The Face-To-Face Visit And Written Order Prior To Delivery
- Face-To-Face Requirements for Orders Used to Obtain Medicare Payment on ACA Items
- ACA Requirement for Indicating Receipt Date of Documentation
- In-Person Visit Requirement for Section 6407 of the Affordable Care Act – Clarification
- Dear Physician Letter: Face-to-Face and Written Order Requirements for High Cost DME

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

Joint DME MAC Publication

This article was originally published in January 2015 and is revised to reflect that external infusion pumps do not require a recertification DIF when the length of need expires and the ordering physician extends the length of need. A revised DIF is the proper form for the supplier to complete.

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

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

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutrition

Initial DIF:A new Initial DIF is required when:

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

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

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

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

DOCUMENTATION

Recertification DIF:A Recertification DIF is required for parenteral and enteral pump (only) when the length of need previously entered on the DIF has expired and the ordering physician is extending the length of need for the item(s).

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

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

DME Improved Checklists Now Available for General Documentation Requirements

Noridian Provider Education and Medical Review have created two new general documentation checklists to aid suppliers in the submission of general documentation. See the Documentation Checklist webpage for more information.

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

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

ACT Meeting Minutes - June 11, 2015

DME Provider Outreach and Education has posted the meeting minutes from the General Ask the Contractor Teleconference (ACT) meeting which was held on June 11, 2015. For complete information, see the ACT page of the Noridian Medicare website.

New Supplier Education Curriculum

Are you a new supplier just starting to bill Medicare for DMEPOS items?

Are you an experienced supplier providing a new DMEPOS product category?

Managers, are you in need of consistent, Medicare-related training material for your staff for new and on-going training?

EDUCATIONAL

Our New Supplier Education Curriculum is customizable to meet the needs of any DMEPOS supplier! This education material is comprised of multiple self-paced, pre-recorded tutorials DMEPOS suppliers and billers can view to develop and improve their Medicare DMEPOS knowledge.

To begin, viewers are encouraged to build their Medicare foundation with the three General Curriculum topics related to General Medicare, Standard Documentation and Medicare Claims and Billing. Next, specialize your Medicare learning with the Policy-Specific Curriculum that pertains to your business and the products you provide to Medicare beneficiaries. Are you a respiratory supplier? View the Oxygen and CPAP Curriculum. Are you a PMD supplier located in California? View our PMD and PAR Curriculum. Each General and Policy-Specific Curriculum concludes with a quiz to test the viewer's retention of the material and is a great tool for training purposes. Upon successful completion of each curriculum, a certificate of completion is made available to the viewer.

View today as the New Supplier Education Curriculum can provide DMEPOS suppliers the foundation necessary for successful Medicare claim submission!

ENDEAVOR

Endeavor Registration Process Change – CEDI Requirement

Effective July 1, 2015, Noridian will no longer accept any registrations with a National Provider Identifier (NPI) that is not registered as an electronic submitter with Common Electronic Data Interchange (CEDI).

Users who have an established Endeavor account will not lose their access at this time. However, any NPI addition for the account must be registered with CEDI. If a registration with an NPI that is not enrolled is received it will be rejected. Once enrolled as an electronic biller, you may re-register for Endeavor.

To enroll with CEDI or for questions about the process, please see the CEDI website.

For questions on Endeavor, email dmeendeavor@noridian.com.

ENTERAL AND PARENTERAL NUTRITION

Navigating the Nutrition Policies

DME Provider Outreach and Education has provided a summary for suppliers to use before dispensing equipment and supplies for Enteral and Parenteral Nutrition.

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

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

The B4185 review currently has an overall potential improper payment rate of **86%** and the B4197 review currently has an overall potential improper payment rate of **94%**.

The top reasons for denial were:

- The medical records did not support coverage criteria.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a permanent impairment.
- No documentation to support the beneficiary had a visit within 30 days prior to certification.

For complete details, see
Parenteral Nutrition (HCPCS B4185, B4197) Quarterly Results of Service Specific Prepayment Review.

Parenteral Nutrition CERT Errors – Documentation Reminder

Joint DME MAC Publication

A recent examination of Comprehensive Error Rate Testing (CERT) reviews for parenteral nutrition claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

Reasons for Denial

- Statutory Requirements
  - Statutory coverage requirements not met – 32%
- Prescriptions
  - Physician's detailed written order (DWO) not submitted with claim – 16%
  - Physician's DWO missing detailed item description – 11%
  - Physician's DWO not signed – 10%
  - Physician's DWO not dated – 4%
- DME Information Form (DIF)
  - Missing DIF – 16%
- Continued Need
  - Missing documentation – 2%
- Continued Use
  - Missing documentation – 4%
- Other
  - Unsigned Clinical Notes – 2%

Payment Rules

Prescriptions:

All items billed to Medicare require a prescription. A DWO is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

Documentation

In the event of a claim review:

- Medicare requires a DWO.
- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements were met.

This article presents a summary of the policy requirements related to the errors identified in a CERT review. The majority of reasons for CERT errors (59%) are completely within the purview of suppliers. Thus, suppliers are encouraged to review their claim submission practices, in order to reduce the high level of CERT errors. Statutory requirements necessary for coverage are not discussed in this article. Please refer to the Parenteral Nutrition LCD and related Policy article for complete information.

Further education regarding this policy is available on your DME MAC Contractor's website.

ENTERAL AND PARENTERAL NUTRITION

Parenteral Nutrition (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 code(s) B4185 and B4197. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The B4185 review involved 125 claims, of which 113 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **92%**.

The B4197 review involved 63 claims, of which 62 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **98%**.

The top denial reasons were:

- The documentation does not support the coverage criteria
- The order is incomplete or missing elements.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- The documentation does not support a permanent impairment.

For complete details, see
Parenteral Nutrition (HCPCS B4185, B4197) Quarterly Results of Service Specific Prepayment Review.

EXTERNAL INFUSION PUMPS

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

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

The E0781 review has an overall potential improper payment rate of **56%** and the E0784 review has an overall potential improper payment rate of **43%**.

The top reasons for denial were:

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No Detailed Written Order (DWO) was received or was incomplete/missing elements.
- No Proof of Delivery (POD) was submitted or was dated prior to the date of service of the claim.
- Documentation does not support a covered indication.

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

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

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

The A4253 has an overall potential improper payment rate of **87%**.

The top reasons for denial were:

- Documentation submitted did not support the actual testing frequency that corroborates with the quantity of supplies that have been dispensed.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation submitted did not support the beneficiary had been evaluated by the physician and documented the reason for additional materials being requested.
- No office notes or medical records were received.

For complete results, see Blood Glucose and Test or Reagent Strips (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review.

Diabetic Testing Supplies (HCPCS A4253KS, A4253KX) Quarterly Results of Documentation Compliance Review

The quarterly edit effectiveness, from March 2015 through May 2015 are as follows:

The A4253KS review involved 14,297 claims, of which 7,854 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **50%**.

The A4253KX review involved 5,711 claims, of which 4,542 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **64%**.

The top reasons for denial were:

- Testing logs of documentation indicating frequency of testing was not submitted.
- No documentation received in response to the Additional Documentation Request (ADR) letter.
- No Proof of Delivery (POD) was submitted.
- Proof of Delivery (POD) was incomplete or missing elements.

For complete details, see Diabetic Testing Supplies (HCPCS A4253KS, A4253KX) Quarterly Results of Documentation Compliance Review.

GLUCOSE MONITORS

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) A4253. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The A4253 review involved 4,220 claims, of which 4,039 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **87%**.

The top denial reasons were:

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

For complete details, see Blood Glucose Test or Reagent Strips (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review.

HOME HEALTH

Home Health Consolidated Billing - HCPCS Codes Used - Quarterly Update

MLN Matters® Number: MM9192
Related Change Request (CR) #: CR 9192
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3269CP
Implementation Date: October 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed

This article, based on Change Request (CR) 9192, provides the quarterly update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of HH services. CR 9192 announces the addition of HCPCS codes 97607 and 97608, negative pressure wound therapies, to the HH consolidated billing therapy code list, effective for services on or after October 1, 2015. These codes replace codes G0456 and G0457, negative pressure wound therapies, which are deleted from the HH consolidated billing therapy code list. In addition, code A7048 replaces code A7043 on the HH Consolidated billing non-routine supply code list, effective for services on or after October 1, 2015. Be sure your staffs are aware of this update.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the HH Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode

(that is, under a home health plan of care administered by an HHA). Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS code is added to the HH consolidated billing non-routine supply code list and will replace code A7043, which is deleted from the same list effective October 1, 2015:

- A7048 - Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each.

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS codes are added to the HH consolidated billing therapy code list and will replace HCPCS codes G0456 and G0457, which are deleted from this list, effective on October 1, 2015:

- HCPCS 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters; and
- HCPCS 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

Additional Information

The official instruction, CR 9192, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3269CP.pdf on the CMS website.

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0260. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The E260 review involved 1,231 claims, of which 896 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **76%**.

The top denial reasons were:

- The documentation does not support the criteria for a semi-electric bed.
- The documentation does not support the criteria for a fixed height bed.
- The documentation does not contain a valid date stamp or similar.
- The order submitted was incomplete or missing elements.

For complete details, see Hospital Beds (HCPCS E0260) Quarterly Results of Service Specific Prepayment Review.

HOSPITAL BEDS

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

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

The E0260 has an overall potential improper payment rate of **73%**.

The top reasons for denial were:

- The documentation submitted does not support the criteria for a semi-electric bed.
- The documentation submitted does not support the criteria for a fixed height bed.
- The documentation does not contain a valid date stamp or similar.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.

For complete details, see
Hospital Beds (HCPCS E0260) Quarterly Results of Service Specific Prepayment Review.

ICD-10

Submitting Correct ICD-10 Codes to Medicare - Information and Resources

MLN Matters® Number: SE1518

Provider Types Affected

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

Provider Action Needed

This MLN Matters® Special Edition article is intended to assist physicians, providers, and suppliers by offering information and resources for submitting correct International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes to Medicare.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act-covered entities. ICD-10-CM, including the "ICD-10-CM Official Guidelines for Coding and Reporting," will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the "ICD-10-PCS Official Guidelines for Coding and Reporting," will replace ICD-9-CM procedure codes.

Use of External Cause and Unspecified Codes in ICD-10-CM

Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a State-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity. If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

All the Medicare claims audit programs will use the same approach under ICD-10 as is used under ICD-9. Physicians, like all providers, are expected to code correctly and have sufficient documentation to support the codes selected. For example, if a physician is treating a patient for diabetes, there should be an ICD-10 code on the claim for diabetes. The level of specificity of the diabetes code selected will not change the coverage and payment of services in most cases.

Information and Resources

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

- General ICD-10-CM/PCS information: http://www.cms.gov/Medicare/Coding/ICD10/index.html on the Centers for Medicare & Medicaid Services (CMS) website;
- ICD-10 Fee-For-Service educational resources, including MLN Matters® articles, MLN products, MLN Connects® videos, and CMS resources: http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html on the CMS website;
- "Coding for ICD-10-CM: More of the Basics" MLN Connects® video: http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences-Items/2014-12-02-ICD-10-Basics.html on the CMS website;
- General Equivalence Mappings:
- http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html on the CMS website; and
- ICD-10 National Coverage Determinations:
- http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website.

Additional Information

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

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

MLN Matters® Number: SE1408 Revised
Related Change Request (CR) #: 7492

This article was revised on June 27, 2015, to clarify language under "Claims that Span the ICD-10 Implementation Date". All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Key Points of SE1408

General Reporting of ICD-10

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

General Claims Submissions Information

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

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

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

Claims that Span the ICD-10 Implementation Date

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

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

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

Table B - Special Outpatient Claims Processing Circumstances

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

Table C – Professional Claims

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

Table D –Supplier Claims

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

Additional Information

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

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

ICD-10 End-to-End Testing – FAQS – Second Revision

MLN Matters® Number: SE1435 Revised

This article was revised on June 9, 2015, to provide updated information for physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Types Affected

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

Provider Action Needed

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

What to Know Prior to Testing

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

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

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

2. What constitutes a testing slot for this testing?

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

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

For each testing slot, you must provide the MAC the following:

- Up to 2 submitter identifiers (IDs);
- Up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and
- Up to 10 Health Insurance Claim Numbers (HICNs).

You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

If you want to change your selected submitter IDs, NPIs, PTANs, or HICNs, you must contact the MAC. If the MAC is not aware of these changes, claims submitted will not be processed.

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

The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information and other documentation such as Certificates of Medical Necessity (CMNs). The

HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. If I was selected for the January 2015 or April 2015 end-to-end testing, do I need to reapply for July 2015 testing?

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

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

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

What to Know During Testing

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

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

2. What dates of service can be used on test claims?

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

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

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

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

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

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to the following MLN Matters® Articles:

- SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims That Span the ICD-10 Implementation Date," located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf on the Centers for Medicare & Medicaid Services (CMS) website;
- SE1408, "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492," located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf on the CMS website; and
- SE1410, "Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015," located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf on the CMS website.

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

Institutional claims that fail RTP editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the ERA, and they will not be available through Direct Data Entry (DDE). If claims accepted by the front end edits do not appear on the ERA, please contact the MAC for further information.

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

5. Will a summary of test claims be provided at the conclusion of testing?

Yes, the MAC will provide testers a summary of all accepted test claims after the April and July testing rounds. These reports will be delivered to testers approximately 4 weeks following the testing week. Reports for April 2015 testing were delivered by May 29.

6. If a CMN or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?

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

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

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

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

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

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

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

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

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

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

Additional Information

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

ICD-10 Testing Approach – Second Revision

MLN Matters® Number: SE1409 Revised

This article was revised on May 29, 2015, to show that the April IOCE is available and that it contains ICD-9 and ICD-10 codes.

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

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

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

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

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

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

Provider-Initiated Beta Testing Tools

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

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

- The April 2015 version of the Integrated Outpatient Code Editor (IOCE) now includes both ICD-9-CM and ICD-10-CM. The files are available at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html on the CMS website. The July 2015 IOCE release will also include both ICD-9-CM and ICD-10-CM. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2015.

Acknowledgement Testing

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

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

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

End-to-End Testing

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

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

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

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

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

Claims Submission Alternatives

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

Additional Information

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

Using the ICD-10-PCS New Technology Section X Codes

MLN Matters® Number: SE1519

Provider Types Affected

This article is intended for all hospitals who submit inpatient claims to Medicare Administrative Contractors (MACs), for services provided to Medicare beneficiaries.

Provider Action Needed

This MLN Matters® Special Edition article is intended to assist hospital providers by offering details about the new International Classification of Diseases, Tenth Edition, Procedure Coding System (ICD-10-PCS) Section X New Technology, as well as specific coding instruction for the new section.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act-covered entities. ICD-10-CM, including the "ICD-10-CM Official Guidelines for Coding and Reporting," will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the "ICD-10-PCS Official Guidelines for Coding and Reporting," will replace ICD-9-CM procedure codes. ICD-10-PCS will be used for reporting inpatient hospital procedures.

Section X New Technology – General Information

Section X New Technology is a section added to ICD-10-PCS beginning October 1, 2015. The new section provides a place for codes that uniquely identify procedures requested via the New Technology Application Process or that capture other new technologies not currently classified in ICD-10-PCS.

Section X was created in response to public comments received regarding New Technology proposals presented at ICD-10 Coordination and Maintenance Committee Meetings, and general issues facing classification of new technology procedures. The public had opposed many requests to add new codes to the existing ICD-10-PCS sections for the use of specific drugs, devices, or supplies in an inpatient setting, even when the code related to an application for New Technology add-on payments.

The new section is simply a separate place for certain new technology procedures, such as infusion of new technology drugs, and was created because the public did not support adding any more of these types of codes to the other sections of ICD-10-PCS. Section X does not introduce any new coding concepts or unusual guidelines for correct coding. In fact, Section X codes maintain continuity with the other sections in ICD-10-PCS by using the same root operation and body part values as their closest counterparts in other sections of ICD-10-PCS. For example, the two new codes for the infusion of ceftazidime-avibactam, a new technology antibiotic that requires unique procedure codes for October 1, 2015, use the same root

operation (Introduction) and body part values (Central Vein and Peripheral Vein) in section X as the infusion codes in section 3 Administration, which are their closest counterparts in the other sections of ICD-10-PCS.

In ICD-10-PCS, the information specified in the seventh character is called the qualifier, and the type of information specified depends on the section. In section X, the seventh character is used exclusively to indicate the new technology group.

The New Technology Group is a number or letter that changes each year that new technology codes are added to the system. For example, Section X codes added for the first year have the seventh character value 1, New Technology Group 1, and the next year that Section X codes are added have the seventh character value 2, New Technology Group 2, and so on. This is a much simpler use of the qualifier than in many other sections of ICD-10-PCS, such as the Medical and Surgical section.

Because it is only used to indicate the update year the code was created, there are no special coding instructions or requirements for the use of the qualifier, because all codes for a particular new technology procedure will all have the same qualifier. Therefore, the New Technology Group has no impact for correct coding. Its function is to allow the section to maintain consistency between the root operation and body part values of the other sections, as described above, and to allow the section to evolve over time, as medical technology evolves.

Section X Coding Instruction

Section X codes are standalone codes. They are not supplemental codes. Section X codes fully represent the specific procedure described in the code title, and do not require any additional codes from other sections of ICD-10-PCS. When section X contains a code title which describes a specific new technology procedure, only that X code is reported for the procedure. There is no need to report a broader, non-specific code in another section of ICD-10-PCS.

For example, code XW04321 Introduction of Ceftazidime-Avibactam Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 1, would be reported to indicate that Ceftazidime-Avibactam Anti-infective was administered via central vein. A separate code from table 3E0 in the Administration section of ICD-10-PCS would not be reported in addition to this code. The X section code fully identifies the administration of the ceftazidime-avibactam antibiotic, and no additional code is needed.

The New Technology section codes are easily found by looking in the ICD-10-PCS Index or the Tables. In the Index, the name of the new technology device, substance or technology for a section X code is included as a main term. In addition, all codes in section X are listed under the main term New Technology. The new technology code index entry for ceftazidime-avibactam is shown below.

Ceftazidime-Avibactam Anti-infective XW0

New Technology Ceftazidime-Avibactam Anti-infective XW0

In the Tables, New Technology codes are displayed like all other ICD-10-PCS tables, with a separate table for each root operation and body system. All section X codes for the root operation Introduction valid for October 1, 2015, are shown in the table below.

Section - X - New Technology

Body System - W - Anatomical Regions

Operation - 0 - Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products

Body Part	Approach	Device / Substance / Technology	Qualifier
3 Peripheral Vein 4 Central Vein	3 Percutaneous	2 Ceftazidime-Avibactam Anti-infective 3 Idarucizumab, Dabigatran Reversal Agent 4 Isavuconazole Anti-infective 5 Blinatumomab Antineoplastic Immunotherapy	1 New Technology Group 1

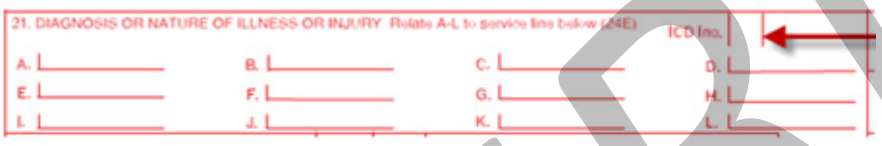
Information and Resources

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

- General ICD-10-CM/PCS information: http://www.cms.gov/Medicare/Coding/ICD10/index.html on the Centers for Medicare & Medicaid Services (CMS) website;
- ICD-10 Fee-For-Service educational resources, including MLN Matters® articles, MLN products, MLN Connects® videos, and CMS resources: http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html on the CMS website;
- General Equivalence Mappings:
- http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html on the CMS website; and
- ICD-10 National Coverage Determinations:
- http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website.

Correct Billing of Diagnosis Indicator on Paper Claims

For DME paper claims received by Noridian on or after October 1, 2015, the diagnosis indicator in Item 21 must be entered correctly to avoid claims denials. For dates of service prior to October 1, 2015, a diagnosis indicator of 9 for ICD-9 must be used. For dates of service on or after October 1, 2015, a diagnosis indicator of 0 (zero) for ICD-10 must be used.



If the indicator field is left blank, the claim will be denied as unprocessable on your remittance advice. A new claim, with the diagnosis indicator appropriately completed, will need to be submitted.

Below are some other reminders about billing claims after ICD-10 implementation:

- ICD-9 and ICD-10 codes cannot be submitted on the same claim. If billing dates of service prior to October 1, 2015, and on/after October 1, 2015, bill two separate claims.
- If billing a date span, use the "from" date of service to determine which ICD diagnosis code set to use.
- Do not submit the decimal point in the diagnosis code.

ICD-10 FAQs: CMNs and Prescriptions

Questions and answers regarding Certificates of Medical Necessity (CMNs) and prescriptions are provided.

Q: I have CMNs for patients that contain ICD-9 diagnosis codes. Do I need to submit new CMNs with ICD-10 codes for claims submitted after the transition to ICD-10?
A: CMS is not requiring suppliers to submit updated Certificates of Medical Necessity (CMNs) for claims submitted on or after the ICD-10 implementation date of October 1, 2015; however, these claims must contain a valid ICD-10 diagnosis code. CMNs created after the transition to ICD-10 must use ICD-10 codes. Suppliers should ensure that the diagnosis code(s) billed on the claim are supported by documentation in the medical record.

Q: After ICD-10 implementation, how should pharmacies handle prescriptions with ICD-9 codes that were written prior to the implementation date?
A: When filling prescriptions that were written prior to the ICD-10 implementation date of October 1, 2015, pharmacies have the option to use the reimbursement mappings posted on the 2015 ICD-10-CM and GEMs and 2015 ICD-10 PCS and GEMs web pages to translate ICD–9 codes into ICD–10. New prescriptions written after the transition to ICD-10 must use ICD-10 codes.

Source: CMS MLN Connects Provider eNews, May 28, 2015

ICD-10 Clarifying Questions and Answers from CMS and the AMA

Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

On July 6, 2015, the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) released a joint statement about their efforts to help the provider community get ready for ICD-10. This statement included guidance from CMS that allows for flexibility in the claims auditing and quality reporting processes.

In response to questions from the health care community, CMS has released "Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities," which provides answers to the most commonly asked questions.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org 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 July 27, 2015

ICD-10 - CMS and AMA Announce Efforts to Help Providers Get Ready

CMS and AMA Announce Efforts to Help Providers Get Ready for ICD-10

With less than three months remaining until the nation switches from ICD-9 to ICD-10 coding for medical diagnoses and inpatient hospital procedures, The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) are announcing efforts to continue to help physicians get ready ahead of the October 1 deadline. In response to requests from the provider community, CMS is releasing additional guidance that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD- 10 code set. For more details, please see the joint announcement on the CMS ICD-10 website.

Recognizing that health care providers need help with the transition, CMS and AMA are working to make sure physicians and other providers are ready ahead of the transition to ICD-10 that will happen on October 1. Reaching out to health care providers all across the country, CMS and AMA will in parallel be educating providers through webinars, on-site training, educational articles and national provider calls to help physicians and other health care providers learn about the updated codes and prepare for the transition.

"As we work to modernize our nation's health care infrastructure, the coming implementation of ICD-10 will set the stage for better identification of illness and earlier warning signs of epidemics, such as Ebola or flu pandemics." said Andy Slavitt, Acting Administrator of the Centers for Medicare and Medicaid Services. "With easy to use tools, a new ICD-10 Ombudsman, and added flexibility in our claims audit and quality reporting process, CMS is committed to working with the physician community to work through this transition."

"ICD 10 implementation is set to begin on October 1, and it is imperative that physician practices take steps beforehand to be ready," said AMA President Steven J. Stack, MD. "We appreciate that CMS is adopting policies to ease the transition to ICD-10 in response to physicians' concerns that inadvertent coding errors or system glitches during the transition to ICD-10 may result in audits, claims denials, and penalties under various Medicare reporting programs. The actions CMS is initiating today can help to mitigate potential problems. We will continue to work with the administration in the weeks and months ahead to make sure the transition is as smooth as possible."

The International Classification of Diseases, or ICD, is used to standardize codes for medical conditions and procedures. The medical codes America uses for diagnosis and billing have not been updated in more than 35 years and contain outdated, obsolete terms.

The use of ICD-10 should advance public health research and emergency response through detection of disease outbreaks and adverse drug events, as well as support innovative payment models that drive quality of care.

CMS' free help includes the "Road to 10" aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation. CMS has also released provider training videos that offer helpful ICD-10 implementation tips.

The AMA also has a broad range of materials available to help physicians prepare for the October 1 deadline. To learn more and stay apprised on developments, visit AMA Wire.

CMS also detailed its operating plans for the ICD-10 implementation. Upcoming milestones include:

- Setting up an ICD-10 communications and coordination center, learning from best practices of other large technology implementations that will be in place to identify and resolve issues arising from the ICD-10 transition.
- Sending a letter in July to all Medicare fee-for-service providers encouraging ICD-10 readiness and notifying them of these flexibilities.
- Completing the final window of Medicare end-to-end testing for providers this July.
- Offering ongoing Medicare acknowledgement testing for providers through September 30th.
- Providing additional in-person training through the "Road to 10" for small physician practices.
- Hosting an MLN Connects National Provider Call on August 27th.

In accordance with the coming transition, the Medicare claims processing systems will not have the capability to accept ICD-9 codes for dates of services after September 30, 2015, nor will they be able to accept claims for both ICD-9 and ICD-10 codes.

Also, at the request of the AMA, CMS will name a CMS ICD-10 Ombudsman to triage and answer questions about the submission of claims. The ICD-10 Ombudsman will be located at CMS's ICD-10 Coordination Center.

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 July 6, 2015

ICD-10 Coding Resources

CMS ICD-10 Coding Resources

List of Valid ICD-10-CM Codes

CMS has posted a complete list of the 2016 ICD-10-CM valid codes and code titles in the 2016 Code Descriptions in Tabular Order ZIP file on the 2016 ICD-10-CM and GEMs web page. See the file named "icd10cm_codes_2016.txt" in the ZIP file for the list.

This file will be useful for physician offices and other providers who want to check to make sure that they are reporting all characters in a valid ICD-10-CM code. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure if additional characters are needed, such as the addition of a 7th character in order to arrive at a valid code.

A similar list of the 2016 ICD-10-PCS valid codes and code titles is available in the 2016 PCS Long and Abbreviated Titles ZIP file on the 2016 ICD-10 PCS and GEMs web page. See the file named "icd10pcs_codes_2016.txt" in the ZIP file for the list.

Use of Unspecified Codes in ICD-10-CM

CMS has a number of resources that explain unspecified codes and how they should be used in ICD-10-CM:

- MLN Matters® Article SE1518, "Information and Resources for Submitting Correct ICD-10 Codes to Medicare"

- ICD-10 Basics MLN Connects National Provider Call - Call Materials from August 22, 2013
- More ICD-10 Coding Basics MLN Connects Call - Call Materials from June 4, 2014
- ICD-10 Coding Basics MLN Connects Video - January 2014
- Coding for ICD-10-CM: More of the Basics MLN Connects Video - December 2014
- Visit the ICD-10 Medicare Fee-For-Service Provider Resources web page for a complete list of Medicare Learning Network educational materials.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and resources to help you prepare. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

ICD-10 ACT Questions and Answers

On April 30, 2015 Noridian held an Ask the Contractor Teleconference (ACT) on the upcoming ICD-10 transition. Suppliers are encouraged to stay informed about ICD-10 by attending events held by Noridian and CMS. Click here to view more information and the mintues from this ACT.

New Interactive Case Studies to Explore ICD-10

Use New Interactive Case Studies to Explore ICD-10 Concepts

The Centers for Medicare & Medicaid Services (CMS) has released interactive case studies that can help you understand key ICD-10 documentation concepts.

Available on the Road to 10 tool at cms.gov/ICD-10, the case studies present:

- Clinical scenarios
- Short quizzes on related coding concepts
- Documentation tips

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 June 10, 2015

ICD-10 Training Resources

Many providers and suppliers are looking for training on ICD-10 from their A/B MAC or DME MAC. Noridian will be providing short audio/video training on some ICD-10 topics, starting with an ICD-10 overview. We will also be holding a webinar on ICD-10 in June. Please be advised, the training conducted by Noridian is not in-depth ICD-10 code training, but rather ICD-10 general information and where to find more resources.

In depth education on ICD-10 codes is provided by many coding organizations. This training is available to the organization members and/or the general public. We encourage our provider/supplier communities to look into in depth ICD-10 code training through these coding organizations.

Additionally, CMS offers a plethora of ICD-10 information on their website. Below are a few training resources for your office:

CMS Using the ICD-10-CM Web-Based Training Course

This Medicare Learning Network® web-based training (WBT) course is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/ Procedure Coding System (ICD-10-CM/PCS). It includes ICD-10-CM/PCS implementation guidance, information on the new ICD-10-CM classification system, and coding examples.

To access the WBT, from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html, scroll to "Related Links" at the bottom of the page, and click on "Web-Based Training Courses." You will need to register as a user to take this course, but the course is free.

CMS "Road to 10" Online Resource for Small Practices

Jumpstart your ICD-10 transition with "Road to 10," found at http://www.roadto10.org/, an online resource built with input from providers in small practices. Road to 10" includes specialty references, web cast series and the capability to build ICD-10 action plans tailored for a medical practice needs. Even if your practice is not small, you will find useful resources at this site, especially if you are just starting your ICD-10 implementation.

For other CMS resources on ICD-10, see http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ResourcesFlyer20141105.pdf

ICD-10 Deadline October 1, 2015 - 100 DAYS AWAY

100 DAYS AWAY: ICD-10 Deadline October 1, 2015
Get Ready Now with the New CMS Quick Start Guide!

While ICD-10 is almost here, you still have time to get ready. But you must get ready now.

Each day this week we are highlighting 1 of the 5 steps from the new Quick Start Guide:

1. Make a Plan
2. Train Your Staff
3. Update Your Processes
4. Talk with Your Vendors and Health Plans, and
5. Test Your Systems and Processes.

Today our focus is:

Step: 1 Make a Plan

- Assign target dates for completing steps outlined here
- Most important, obtain access to ICD-10 codes. The codes are available from many sources and in many formats:
  - Code books
  - CD/DVD and other digital media
  - Online (e.g., go to cms.gov/ICD10 and select "2016 ICD-10-CM and GEMS" to download 2016 Code Tables and Index)
  - Practice management systems
  - Electronic health record (EHR) products
  - Smartphone apps
- Decide role(s) your clearinghouse(s) will play in your transition. Some providers who are not ready could benefit from contracting with a clearinghouse to submit claims:
  - Clearinghouses can help by:
    - Identifying problems that lead to claims being rejected
    - Providing guidance about how to fix rejected claims (e.g., more or different data need to be included)

- Clearinghouses **cannot** help you code in ICD-10 codes unless they offer third-party billing/coding services

Tips

- You must use:
  - ICD-10 codes for all services provided on or after October 1
  - ICD-9 codes for all services provided before October 1
- Identify everywhere in your practice that you use ICD-9 codes to make sure you know what processes and systems need to be updated for ICD-10; for example:
  - Patient registration and scheduling
  - Clinical documentation/health records
  - Referrals and authorizations
  - Order entry
  - Coding
  - Billing
  - Reporting and analysis
- Even clearinghouses that offer coding and billing services cannot translate ICD-9 codes to ICD-10 codes unless they have the detailed clinical documentation required to select the right code
- Practices that do not prepare for ICD-10 risk disruptions in cash flow
- For a more in-depth approach to planning, see the Action Plan section of the Road to 10

To learn more about getting ready, visit cms.gov/ICD10 for free resources including the Road to 10 tool designed especially for small and rural practices, but useful for all health care professionals.

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 June 22, 2015

ICD-10 News: Quick Start Step 2 - Train Your Staff

Get Ready Now with the New CMS Quick Start Guide!

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Each day this week we are highlighting 1 of the 5 steps from the new Quick Start Guide:

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2. Train Your Staff
3. Update Your Processes
4. Talk with Your Vendors and Health Plans, and
5. Test Your Systems and Processes.

Today our focus is:

Step: 2 Train Your Staff

- Train staff on ICD-10 fundamentals using the wealth of free resources from CMS, which include the ICD-10 website, Road to 10, Email Updates, National Provider Calls, and webinars. Free resources are also available from:

- Medical societies, health care professional associations
- Hospitals, health systems, health plans, vendors

- Identify top codes. What ICD-9 diagnosis codes does your practice see most often? Target the top 25 to start. You might want to look at common diagnosis codes available from:
  - Road to 10 (see Specialty References)
  - Medical specialty societies
  - Using the documentation available, code current cases in ICD-10. Flag any cases where more documentation is needed.

Tips

- Training for **clinical staff**—e.g., physicians, nurse practitioners, physician assistants, registered nurses—should focus on documentation, new coding concepts captured in ICD-10
- Training for **coding and administrative staff**—e.g., coders, billers, practice managers—should focus on ICD-10 fundamentals
- You can review your superbills, encounter forms, and practice management system reports to identify your most commonly used ICD-10 codes
- If time permits, expand your ICD-10 coding of current cases to include 50 or more of your top codes, until 80% of your claims are covered
- You don't have to use 68,000 codes—as you do now, your practice will likely use a very small subset of ICD-10 codes
- You will use a similar process to look up ICD-10 codes that you use with ICD-9
- While crosswalks from ICD-9 to ICD-10 can be useful references, ICD-10 codes should be based on the clinical documentation rather than selected from a crosswalk
- Practices that do not prepare for ICD-10 will not be able to submit claims for services performed on or after October 1, 2015.

To learn more about getting ready, visit cms.gov/ICD10 for free resources including the Road to 10 tool designed especially for small and rural practices, but useful for all health care professionals.

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 June 23, 2015

ICD-10 News: Quick Start Step 3 – Update Your Processes

Get Ready Now with the New CMS Quick Start Guide!

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Each day this week we are highlighting 1 of the 5 steps from the new Quick Start Guide:

1. Make a Plan
2. Train Your Staff
3. Update Your Processes
4. Talk with Your Vendors and Health Plans, and
5. Test Your Systems and Processes.

Today our focus is:

Step: 3 Update Your Processes

- It is crucial to update hard-copy and electronic forms (e.g., superbills, CMS 1500 forms)
- Resolve any documentation gaps identified while coding top diagnoses in ICD-10
- Make sure clinical documentation captures key new coding concepts:
  - Laterality—or left versus right
  - Initial or subsequent encounter for injuries
  - Trimester of pregnancy
  - Details about diabetes and related complications
  - Types of fractures

Tips

- Create a documentation checklist for any new concepts that need to be captured for ICD-10 coding
- Remember that ICD-10 does not change the requirements for good documentation, which is always about capturing the complete clinical picture in order to provide high-quality patient care
- Review NCDs and LCDs with ICD-10 codes to ensure consistency with internal policies (e.g., coding, billing, and documentation processes)
- Outpatient and office procedure codes aren't changing—ICD-10 does not affect the use of CPT and HCPCS coding for outpatient and office procedures

To learn more about getting ready, visit cms.gov/ICD10 for free resources including the Road to 10 tool designed especially for small and rural practices, but useful for all health care professionals.

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.

ICD-10 News: Quick Start Step 4 – Talk to Your Vendors and Health Plans

Get Ready Now with the New CMS Quick Start Guide!

While ICD-10 is almost here, you still have time to get ready. But you must get ready now.

Each day this week we are highlighting 1 of the 5 steps from the new Quick Start Guide:

1. Make a Plan
2. Train Your Staff
3. Update Your Processes
4. Talk with Your Vendors and Health Plans, and
5. Test Your Systems and Processes.

Today our focus is:

Step: 4 Talk to Your Vendors and Health Plans

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

Tips

- You can use forms available in the Road to 10's Template Library to guide discussions with vendors, health plans, clearinghouses, and billing services
- Double check that you've identified all systems that use ICD codes—e.g., practice management systems, electronic health record (EHR) products—when contacting vendors
- Update contracts with vendors and health plans as needed
- Transition costs for small medical practices could be substantially lower than projected earlier:
  - Many EHR vendors are including ICD-10 in their systems or upgrades—at little or no cost to their customers
  - Software and systems costs for ICD-10 could be minimal for many providers

To learn more about getting ready, visit cms.gov/ICD10 for free resources including the Road to 10 tool designed especially for small and rural practices, but useful for all health care professionals.

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 June 25, 2015

ICD-10 News: Quick Start Step 5 – Test Your Systems and Processes

Get Ready Now with the New CMS Quick Start Guide!

While ICD-10 is almost here, you still have time to get ready. But you must get ready now.

Each day this week we are highlighting 1 of the 5 steps from the new Quick Start Guide:

1. Make a Plan
2. Train Your Staff
3. Update Your Processes
4. Talk with Your Vendors and Health Plans, and
5. Test Your Systems and Processes.

Today our focus is:

Step: 5 Test Your Systems and Processes

- Verify that you can use your ICD-10-ready systems to:
  - Generate a claim
  - Perform eligibility and benefits verification
  - Schedule an office visit
  - Schedule an outpatient procedure
  - Prepare to submit quality data
  - Update a patient's history and problems
  - Code a patient encounter
- Test your systems with partners like vendors, clearinghouses, billing services, and health plans; focus on those partners that you work with most often
  - Medicare providers can conduct acknowledgement testing with their Medicare Administrative Contractors (MACs) until the October 1 compliance date

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

Tips

- Your clearinghouses and billing services can conduct Medicare acknowledgement testing on your behalf
- Many major health plans report that they have portals or other options in place for providers who cannot submit ICD-10 claims electronically
- If you think you might need to use an alternate claims submission method for Medicare, get started now
  - Allow time for you and your staff to complete free training on billing software or portals before October 1
  - You must register for each MAC portal that you use
- If you are eligible to submit paper claims for Medicare and wish to do so, order CMS 1500 forms from the Government Publishing Office or your office supply store
  - Photocopies cannot be used because they cannot be scanned correctly

To learn more about getting ready, visit cms.gov/ICD10 for free resources including the Road to 10 tool designed especially for small and rural practices, but useful for all health care professionals.

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 June 26, 2015

Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Documentation Compliance Review

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

The J7507 review has an overall potential improper payment rate of **36%**, the J7517 review has an overall potential improper payment rate of **42%**, the J7518 review has an overall potential improper payment rate of **33%** and the J7520 review has an overall potential improper payment rate of **44%**.

The top reasons for denial were:

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No documentation for refill requirements was provided.
- No detailed written order (DWO) was submitted.
- Proof of Delivery (POD) was invalid or not submitted.

For complete details, see Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Documentation Compliance Review.

New IVIG Demonstration Supplier Frequently Asked Question

NHIC, the Intravenous Immune Globulin (IVIG) Demonstration contractor, provides a new frequently asked question regarding the administration code Q2052.

How do suppliers handle claims for beneficiaries who are enrolled in the IVIG Demonstration and the administration code (Q2052) was not submitted on the same claim as the drug?

The supplier would request a written reopening with the reason noted on their request. For example:

> "We learned that this beneficiary is enrolled in the IVIG Demonstration. Because the demo administration code (Q2052) must be billed on the same claims as the drug code, please reopen CCN XXX and add this service line for Q2052."

When there are multiple claims where the Q2052 has not been added to the same claim as the drug, the supplier can add a spreadsheet of the affected claims to the written reopening request.

More information regarding the IVIG Demonstration can be found at http://www.medicarenhic.com.

IVIG Hot Line - (844)-625-6284 - (8am - 5pm Monday-Friday ET)
Please call us at this number with any IVIG Demonstration questions.

IVIG Demonstration Q2052 Billing Reminder

NHIC, Corp. has identified Intravenous Immune Globulin (IVIG) Demonstration claims where the drugs are being automatically billed without the demonstration service code. This is incorrect billing that will cause the demonstration service code (Q2052) to deny when it is billed alone on a subsequent claim.

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

In cases where the drug is mailed or delivered to the patient prior to administration, suppliers should not bill the drug until the administration of the drug (the "Q2052" claim line) has been performed. Both services should be billed on the same claim and the date of service for the administration of the drug (the "Q2052" claim line) may be no more than 30 calendar days after the date of service on the drug claim line and within the same calendar year.

No more than one unit of demonstration services (Q2052) shall be billed per claim line.

Additional information about the Medicare IVIG Demonstration is available at:
http://www.medicarenhic.com/ivigdemo/default.aspx.

Draft Policies Release for Comment Bulletin Article

The Centers for Medicare & Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS). The DME MACs are proposing two revised LCDs and one new LCD. These LCDs require a 45-day public comment period. **The comment period for these LCDs begins on Thursday, July 16, 2015 and ends at Close of Business (COB) on Monday, August 31, 2015.**

The summaries below highlight only the major points in each LCD. Each draft LCD should be completely reviewed prior to the preparation of comments.

External Infusion Pumps (revision to existing LCD)

- Revises the criteria for reimbursement of intravenous inotropic medication

Bowel Management Devices (new LCD)

- Provides information necessary for processing claims for these technologies based upon their benefit category coverage status.

Lower Limb Prostheses (revision to existing LCD)

- Revises coverage for the provision of definitive prosthetic components in lieu of an immediate or preparatory prosthesis
- Implements a requirement for an independent medical exam to determine functional status
- Implements a requirement for a new amputee to participate in a rehabilitation program prior to the provision of a definitive prosthesis.
- Revises functional level modifiers (K-level modifiers)
- Revises codes for prosthetic feet

We are soliciting comments on these draft policies from physicians, manufacturers, suppliers and other professionals involved in the ordering of provision of these items. **For the External Infusion Pump policy, we are only soliciting comments regarding the revised criteria for the reimbursement of intravenous inotropic medications.**

We recommend that you distribute these draft policies to selected members of your organization for review and comment. If you disagree with any aspect of a policy, you should be very specific in your comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy.

If you are providing comments on more than one LCD, please provide a separate communication for each policy with the policy indicated in the subject line of the submission.

All comments will be collected at a single point of contact. Please submit your comments electronically to the DME MAC medical director at the e-mail address below no later than Close of Business (COB) on the date indicated above for close of the comment period for the applicable LCD.

Stacey V. Brennan, M.D., FAAFP

Medical Director, DME MAC, Jurisdiction B

National Government Services
8115 Knue Rd.
Indianapolis, IN 46250-1936

DMAC_Draft_LCD_Comments@anthem.com

The comment process requires a public meeting. A joint DME MAC public meeting will be held on **August 26, 2015, from 08:00 AM EDT until 12:00 PM EDT** at:

Airport Square Business Park,

1304 Concourse Drive,

Linthicum, MD 21090

Interested parties from any DME MAC jurisdiction may attend this public meeting. **This meeting provides the opportunity for brief oral presentations only.** There is no Question and Answer or discussion period as a part of the meeting. In order for oral presentation comments to be considered, they must be presented through the formal comment process.

Advance registration is required for attendance at the public meeting and the registrant must indicate whether participating as a presenter or attendee (listen only). Registration is online at:

http://apps.ngsmedicare.com/ADC/EventList.aspx?fromdate=8/1/2015&todate=8/31/2015&display=Month&type=public&eventidn=3031&view=EventDetails&information_id=5739

This registration must be completed no later than **COB Friday, August 21, 2015.** Registrants must include their name, contact information, organization, whether attending in person or via teleconference and the policy(s) upon which oral presentations will be made in their registration information.

The amount of time allotted to presentations is based upon the number of registered speakers. There shall be one presentation per company or organization. The DME MAC medical directors reserve the right to limit speakers and time as appropriate. Speakers should be prepared to adjust the length of their presentation depending upon the number of speakers.

IMPORTANT REMINDER Suppliers/providers are cautioned not to make any changes to business practices based upon the information contained in these draft documents. Drafts are often substantially revised based upon the comments received. When all comments have been reviewed, revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on individual DME MAC websites, allowing for adequate notice before the policies' effective date.

Refer to each DME MAC web site for additional information about policy development and copies of the draft LCDs.

Jurisdiction A – www.medicarenhic.com

Jurisdiction B – www.ngsmedicare.com

Jurisdiction C – www.cgsmedicare.com/jc

Jurisdiction D – http://med.noridianmedicare.com/web/jddme

Thank you for your participation in our policy revision process.

Sincerely,

Stacey V. Brennan, M.D., FAAFP

On behalf of:

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LCD and Policy Article Revisions Summary for June 11, 2015 – Revised

This article was originally published on June 11, 2015 and is revised to reflect the removal of the future Surgical Dressings Local Coverage Determination and Policy Article.

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 Facial Prosthesis, Ostomy Supplies, Tracheostomy Care Supplies and Urological Supplies. Please review each entire LCD and each related PA for complete information.

Facial Prosthesis
LCD
Revision Effective Date: 08/01/2015

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
Added: Instructions for Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS
(Note: Standard Documentation Language updates noted above are effective for DOS on or after 10/31/2014)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Language for HCPCS Codes A4450, A4452, A5120 when submitted without correct modifier

Policy Article

Revision Effective Date: 08/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Language for HCPCS codes A4450, A4452, A5120 that are billed without correct modifier

Ostomy Supplies
LCD
Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Removed: ICD-9 references
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Language for HCPCS codes A4450, A4452 and A5120 when submitted without correct modifier

Policy Article
Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: ICD-9 references
Revised: Language for HCPCS codes A4450, A4452, A5120 when submitted without correct modifier

Tracheostomy Care Supplies
LCD
Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
(Note: Standard Documentation Language updates noted above are effective for DOS on or after 10/31/2014)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: ICD-9 references
Added: Language for HCPCS codes A4450, A4452, A5120 when submitted without correct modifier

Policy Article
Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Language for HCPCS codes A4450, A4452, A5120 when submitted without correct modifier

Urological Supplies
LCD
Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
(Note: Standard Documentation Language updates noted above are effective for DOS on or after 10/31/2014)
Added: Language for HCPCS codes A4217, A4450, A4452 when submitted without correct modifier

Policy Article
Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: KX modifier reference from this section
Revised: Language for HCPCS codes A4217, A4450, A4452 when submitted without correct modifier

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 July 23, 2015

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that has been revised and posted for Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics). Please review the entire LCD and related PA for complete information.

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
LCD
Revision Effective Date: 07/01/2015

HCPCS CODES:
Added: HCPCS code Q9978
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Q9978 to modifier billing instructions effective 07/01/2015

Policy Article
Revision Effective Date: 07/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Q9978 for billing after 07/01/15
Removed: Drug name Akynzeo®
CODING GUIDELINES:
Added: Q9978 for billing after 07/01/15
Removed: Drug name Akynzeo®

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

LCD and Policy Article Revisions Summary for August 20, 2015

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

Commodes
LCD
Revision Effective Date: 10/31/2014 (August 2015 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Incorporated NCD 280.1 coverage statement regarding, bidets, bidet toilet seats and similar

Policy Article
Revision Effective Date: 04/01/2013 (August 2015 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Coverage statement for bidets and similar items
CODING GUIDELINES:
Added: Code description for bidets, bidet toilet seats and similar items

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

MOBILITY DEVICES

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) K0001, K0003 and K0004. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The K0001 review involved 784 claims, of which 556 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **65%**.

The K0003 review involved 264 claims, of which 219 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **80%**.

The K0004 review involved 112 claims, of which 98 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **83%**.

The top denial reasons were:

- The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- The documentation submitted did not support that the use of a manual wheelchair will significantly improve the beneficiary's ability to participate in mobility related activities of daily living (MRADLs) and the beneficiary will use it on a regular basis in the home.

- The documentation submitted did not support that the beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.
- The documentation submitted did not support that the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.
- The documentation submitted did not support that the beneficiary requires a lightweight wheelchair (K0003).
- The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).

For complete details, see Manual Wheelchairs (HCPCS K0001, K0003, K0004) Quarterly Results of Service Specific Prepayment Review.

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

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

The K0004 has an overall potential improper payment rate of **81%**.

The top reasons for denial were:

- The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- The documentation submitted did not support that the beneficiary's home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided.

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

PMD Prior Authorization Requests Top Reasons for Non-Affirmation

The top reasons for Power Mobility Device (PMD) Prior Authorization Request (PAR) non-affirmation from March 2015 through May 2015 have now been posted. For complete details, see the PMD Prior Authorization page.

Correct Coding - Modifiers – AU, AV, and AW

Joint DME MAC Publication

HCPCS modifiers have been established for use when items are furnished in conjunction with various supplies listed in multiple DME MAC Local Coverage Determinations (LCD) and related Policy Articles (PA). These modifiers are effective for dates of service (DOS) on or after January 1, 2003, and claims submitted without the appropriate modifiers are currently denied as non-covered. Effective for dates of service on or after August 1, 2015, claims submitted without the appropriate modifier will be rejected as missing information. The modifier narratives are:

- AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
- AV - Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
- AW - Item furnished in conjunction with a surgical dressing

These modifiers identify items that are eligible for reimbursement under multiple benefit or payment categories. At this time, the only codes with which these modifiers may be used are:

- A4217 – Sterile water/saline, 500 ml
- A4450 – Tape, non-waterproof, per 18 square inches
- A4452 – Tape, waterproof, per 18 square inches
- A5120 – Skin barrier, wipes or swabs, each
- A6531 – Gradient compression stocking, below knee, 30-40 MMHG, each
- A6532 – Gradient compression stocking, below knee, 40-50 MMHG, each
- A6545 – Gradient compression stocking, wrap, non-elastic, below knee, 30-50 MM HG, each

For example, tape used with a facial prosthesis must be billed using the AV modifier. Tape used with an ostomy pouch must be billed with the AU modifier. Tape used with a surgical dressing must be billed using the AW modifier. The use of specific modifiers is addressed in each LCD and related PA in which these modifiers are applicable. Suppliers should consult the appropriate LCD and related PA for additional coverage, coding and documentation requirements.

These modifiers must not be used with any other HCPCS codes. Use of these modifiers with other codes will result in the return or rejection of the claim line(s) for incorrect modifier use.

Claims for codes A4217, A4450, A4452, A5120, A6531, A6532 and A6545 submitted without an AU, AV or AW modifier (as applicable) with dates of service on or after August 1, 2015, will rejected as missing information and must be resubmitted with the correct modifier applied.

Reference: ANWG 02.45; PM AB-02-152

NEBULIZERS

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS codes J7605 and J7626. The quarterly edit effectiveness, from January 2015 through March 2015 are as follows:

The J7605 review involved 1,343 claims, of which 510 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **42%**.

The J7626 review involved 3,194 claims, of which 1,501 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **47%**.

The top denial reasons were:

- No office notes or medical records were provided.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No documentation for refill requirements provided.
- No Proof of Delivery (POD) submitted.

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

NEGATIVE PRESSURE WOUND THERAPY

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E2402. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The E2402 review involved 79 claims, of which 53 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **62%**.

The top denial reasons were:

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

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

Common CERT Denials for Lower Limb Prosthesis Claims

Noridian provides explanations to common Comprehensive Error Rate Testing (CERT) errors regarding Lower Limb Prostheses (LLP).

CERT Error Comment: Missing the referring physician's detailed written order which includes detailed description and/or HCPCS for each service billed.

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

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

- Description of the item (may be either a narrative description or a brand name/model number)
- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

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

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

CERT Error Comment: Missing the referring physician's clinical records that support the need to replace components for lower limb prosthesis.

The reason for replacement must be documented by the treating physician, either on the order or in the medical record, and must fall under one of the following:

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

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

For continued medical need with all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs,

information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial date of service (DOS) to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

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

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

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

Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

CERT Error Comment: Missing documentation to support the prosthetic services were provided by a qualified professional; certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or by the Board for Orthotist/Prosthetist Certification, or is credentialed and approved by a program that the Secretary determines meets the standards that are necessary to provide such prosthetics and orthotics.

Per the Social Security Act 1834(h)(1)(F), no payment shall be made for custom fabricated orthotics or prosthetics unless the item is furnished by a qualified practitioner AND fabricated by a qualified practitioner or a qualified supplier at a facility that meets such criteria as the Secretary determines appropriate. Examples of acceptable documentation to suffice this requirement can include:

1. Authenticated supplier records which includes credentials.
2. Signature log which includes credentials.
3. Signature attestation for unsigned documents which includes credentials.
4. Copy of their certification.

CERT Error Comment: Referring physician's documentation supporting the beneficiary's current functional capabilities and his/her expected functional potential.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

1. The beneficiary's past history (including prior prosthetic use if applicable); and
2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
3. The beneficiary's desire to ambulate.

The records must document the beneficiary's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

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

Joint DME MAC Publication

This is a correction to articles previously published April 30, 2015, and March 27, 2014.

This article is being republished to correct some typographical errors in HCPCS codes narrative descriptors for L0627 and L0642.

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.

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

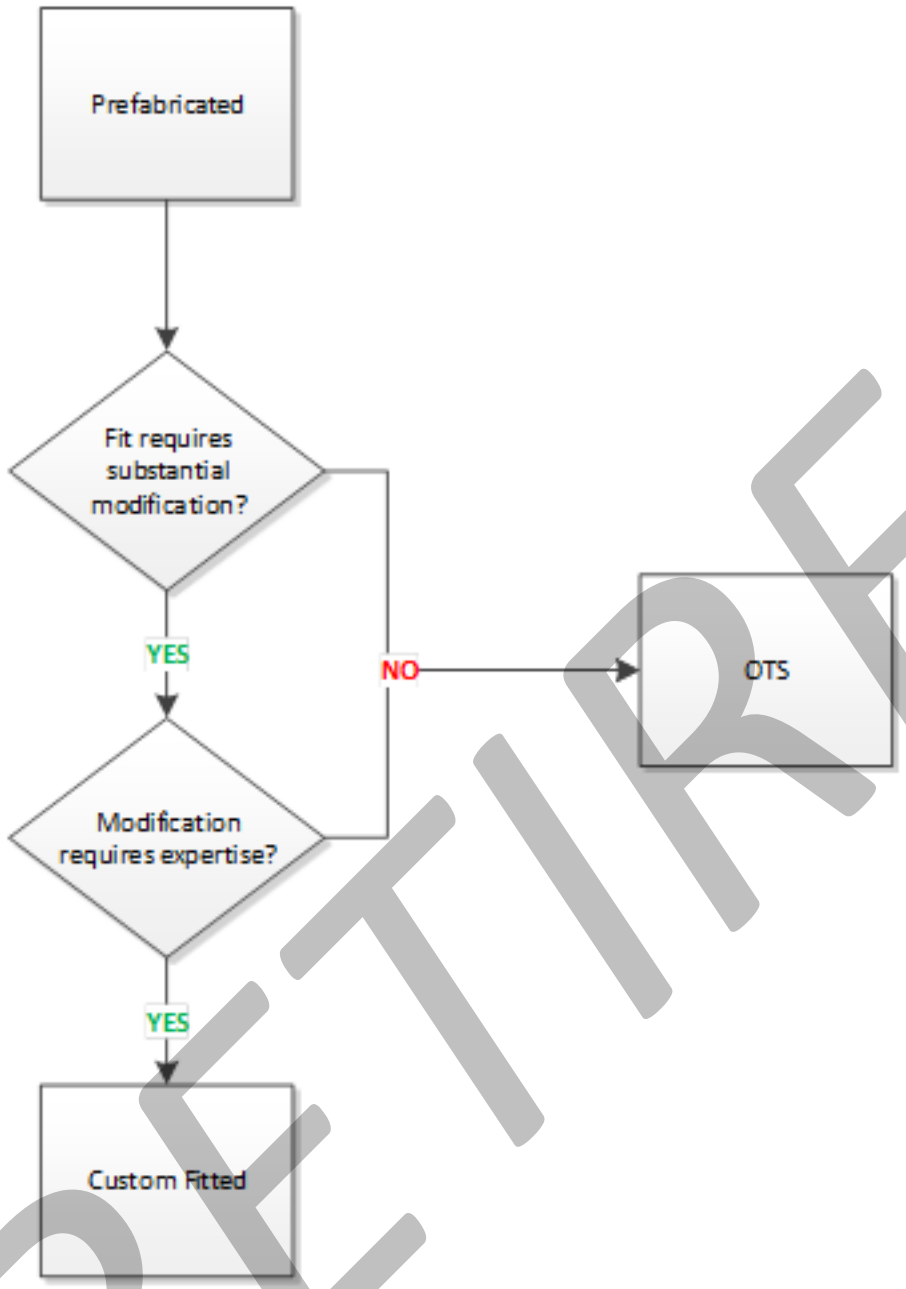
The following question and answer relates to whether a prefabricated orthotic is properly billed using a code for a custom fitted orthotic versus one furnished off-the-shelf and does not address medical necessity for the item. The descriptors for the HCPCS codes for custom fitted orthotics include the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

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



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

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
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

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

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, 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, 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 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
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

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

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
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

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

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
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
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

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
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

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
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
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

Lower Limb Prostheses (HCPCS L5980, L5981, L5987) Quarterly Results of Service Specific Prepayment Review

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

The L5980 review currently has an overall potential improper payment rate of **83%**, the L5981 review currently has an overall potential improper payment rate of **78%** and the L5987 review currently has an overall potential improper payment rate of **70%**.

The top reasons for denial were:

- Documentation does not support the functional level billed on the claim.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support the medical necessity for replacement item.
- Documentation does not support the medical necessity for the item requested.
- Documentation does not support coverage criteria.

For complete details, see Lower Limb Prostheses (HCPCS L5980, L5981, L5987) Quarterly Results of Service Specific Prepayment Review.

Lower Limb Prosthesis Draft LCD Bibliography

The DME MACs released a draft revision of the Lower Limb Prosthesis Local Coverage Determination (LCD) for comment on July 16, 2015. The comment period runs through August 31, 2015. The policy template provides an optional field to list the references used in the preparation of a policy revision. As a general courtesy, the DME MACs provide a bibliography when policies are released for comment. The bibliography for this draft was inadvertently omitted during the publication process. The bibliography [PDF] is provided on the Draft LCD page. We regret any inconvenience.

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L1832 and L1843. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The L1832 review involved 89 claims, of which 89 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **100%**.

The L1843 review involved 93 claims, of which 92 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **99%**.

The top denial reasons were:

- The documentation does not justify the code selected for custom fitted versus off-the-shelf.
- The documentation does not support knee instability or that the beneficiary is ambulatory.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- The Proof of Delivery (POD) is invalid.

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

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L0648 and L0650. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The L0648 review involved 154 claims, of which 101 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **66%**.

The L0650 review involved 153 claims, of which 106 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **69%**.

The top reasons for denial were:

- No documentation was submitted to support coverage criteria.
- The Proof of Delivery (POD) was invalid.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- A Detailed Written Order (DWO) or dispensing order was not received.
- No documentation was submitted to support the reason for replacing the item.

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

OSTEOGENESIS STIMULATORS

Osteogenesis Stimulators (HCPCS E0748) Results of Service Specific Prepayment Probe Review

The Jurisdiction D, DME MAC, Medical Review Department completed a service specific prepayment probe review of HCPCS code E0748. This review was initiated based on a high error rate in a widespread review and the results are as follows:

The E0748 resulted in an overall potential improper payment rate of **56%**.

The top reasons for denial were:

- The documentation does not contain a valid date stamp or similar.
- Proof of Delivery (POD) was invalid.
- Detailed Written Order (DWO) does not contain the practitioners National Provider Identifier (NPI).
- The medical records did not support coverage criteria.

For complete details, see
Osteogenesis Stimulators (HCPCS E0748) Results of Service Specific Prepayment Probe Review.

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 E1390) Quarterly Results of Documentation Compliance Review

The quarterly edit effectiveness results, from March 2015 through May 2015, are as follows:

The E1390 review involved 1,764 claims, of which 494 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **31%**.

The top reasons for denial were:

- No documentation received in response to the Additional Documentation Request (ADR) letter.
- No documentation to support an office visit occurred within 30 days.
- The Proof of Delivery (POD) was dated prior to the date of service of the claim.
- No office notes or medical records were provided.

For complete details, see Oxygen and Oxygen Equipment (HCPCS E1390) Quarterly Results of Documentation Compliance Review.

Physicians! Are You Ordering Oxygen For Your Patient?

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

Your medical record documentation must show that other alternative treatments (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried or considered and deemed clinically ineffective. The documentation must show the patient was seen within 30 days prior to the start of oxygen therapy. The medical record must show the medical condition necessitating the home use of oxygen therapy. The medical record and/or prescription would indicate the oxygen flow rate (e.g., two liters per minute), and the estimation of the frequency (10 minutes per hour), duration of use (12 hours per day) and duration of need (six months). You must specify the type of oxygen delivery system to be used (i.e., portable/stationary concentrator, compressed gas portable/stationary, liquid portable/stationary).

Medicare can make payment for home oxygen supplies and equipment when the patient's medical record shows the patient has significant hypoxemia and meets medical documentation, test results, and health conditions as specified in the CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.2.

You must complete and sign Form CMS-484 (Certificate of Medical Necessity (CMN): Oxygen). However, the CMN itself is not considered part of the medical record. All information included in the CMN must be supported by the contemporaneous medical record. You can find instructions on completing this form in the CMS IOM Publication 100-08, Chapter 5.

The Comprehensive Error Rate Testing (CERT) contractor has identified multiple errors in the claims received for oxygen equipment and supplies. These errors include missing physician clinical records showing the patient's condition and the continued need for oxygen, missing signed and dated order from the physician when changing the oxygen liter flow rate, missing copy of the oxygen saturation testing, and missing treating physician's re-evaluation for recertification CMN.

Help your patients and the Medicare program by verifying you have the medical record documentation to support the order and supply of oxygen for your patients. This allows Medicare to pay claims appropriately.

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0434 and E0439. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The E0434 review involved 93 claims, of which 61 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **51%**.

The E0439 review involved 110 claims, of which 73 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **63%**.

The top denial reasons were:

- The documentation does not contain a valid date stamp or similar.
- No documentation was provided to support the diagnosis.
- No documentation was provided to support an alternative treatment.
- No Written Order Prior to Delivery (WOPD) was received.
- The Proof of Delivery (POD) was invalid.

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

PAP DEVICES

Continuous Positive Airway Pressure (PAP) Devices (HCPCS E0601KH, E0601KJ) 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) E0601 for the first month of billing (KH modifier) and months 4-13 of billing (KJ modifier). The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The E0601KH review involved 3,480 claims, of which 1,369 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **37%**.

The E0601KJ review involved 2,125 claims, of which 876 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **44%**.

The top denial reasons were:

- The documentation does not contain a valid date stamp or similar.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- The order was signed after the date of delivery.
- The documentation did not support coverage criteria for E0601KH.
- The documentation did not meet coverage criteria for continued coverage beyond the first three months for E0601KJ.

For complete details, see Continuous Positive Airway Pressure (PAP) Devices (HCPCS E0601KH, E0601KJ) Quarterly Results of Service Specific Prepayment Review.

PRESSURE REDUCING SUPPORT SURFACES

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

The quarterly edit effectiveness results from February 2015 through May 2015 are as follows:

The E0181 review involved 242 claims, of which 114 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **52%**.

The E0185 review involved 163 claims, of which 104 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **63%**.

The top denial reasons were:

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

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

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

The quarterly edit effectiveness results from February 2015 through May 2015 are as follows:

The E0277 review involved 111 claims, of which 62 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **62%**.

The top reasons for denial were:

- Documentation submitted does not meet coverage criteria.
- The order submitted is incomplete or missing elements.
- No documentation was received in response to Additional Documentation Request (ADR) letter.
- Documentation submitted does not include staging of pressure ulcer.

For complete details, see Group 2 Pressure Reducing Support Surfaces (HCPCS E0277) Quarterly Results of Service Specific Prepayment Review.

REIMBURSEMENT

ASP Quarterly Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – October 2015

MLN Matters® Number: MM9248
Related Change Request (CR) #: CR 9248
Related CR Release Date: July 10, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3290CP
Implementation Date: October 5, 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) 9248 which instructs MACs to download and implement the October 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the July 2015, April 2015, January 2015, and October 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 October 5, 2015, with dates of service October 1, 2015, through December 31, 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 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
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014

NOTE: 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, CR9248 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3290CP.pdf on the CMS website.

DMEPOS Fee Schedule – July 2015 Quarterly Update – Revised

MLN Matters® Number: MM9177 Revised
Related Change Request (CR) #: CR 9177
Related CR Release Date: May 29, 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 #: R3277CP
Implementation Date: July 6, 2015

This article was revised on May 30, 2015, to reflect the revised CR9177 issued on May 29. In the article, the CR release date, transmittal number and the Web address for accessing the article are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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.

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/R3277CP.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).

SGD and Accessories under the Payment Category for Inexpensive or Routinely Purchased DME

MLN Matters® Number: MM9179
Related Change Request (CR) #: CR 9179
Related CR Release Date: June 12, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1511OTN
Implementation Date: October 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for speech generating devices (SGD) and accessories provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 9179, which provides instructions to MACs to change the DME payment category for SGDs and accessories essential for the effective use of the SGD from capped rental (CR) to inexpensive or routinely purchased (IN), effective for SGD and their accessories furnished between October 1, 2015, through September 30, 2018.

Effective for claims with dates of service on or after October 1, 2015, if the beneficiary opts to purchase the SGD, MACs will deduct the cumulative allowed amount for any and all previously paid claims for the item from the allowed amount for the purchase of the item so that payment for purchase of the item does not exceed the fee schedule amount for purchase of the equipment.

Background

Change Request 9179 provides instructions regarding the recent amendment of Section 1834(a)(2)(A) of the Act, that changes the payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015, and September 30, 2018, from capped rental to inexpensive or routinely purchased.

As a result of the amendment, SGDs (and their accessories) furnished between October 1, 2015, and September 30, 2018, are now classified as inexpensive or routinely purchased items and subject to the payment rules outlined in Section 1834(a)(2) of the Act. Items in this payment category are paid on a purchased new (NU), purchased used (UE) or rental (RR) basis. Total payments for items in this category (sum of allowed charges for all claims for rental or purchase) may not exceed the fee schedule amount for purchase of NU.

The NU, UE or RR fee schedule amounts for the SGD and accessory codes will be provided on the October 2015 DMEPOS fee schedule update.

Additional Information

The official instruction, Change Request 9179, issued to your MAC regarding this change, is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1511OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM9141
Related Change Request (CR) #: CR 9141
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3272CP
Implementation Date: October 5, 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9141 informs MACs about the changes to the Claim Status Category and Claim Status Codes.

Background

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ on the Internet.

All code changes approved during the June 2015 committee meeting shall be posted on those sites on or about July 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR9141.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9141.

Additional Information

The official instruction, CR9141, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3272CP.pdf on the CMS website.

Phase III ERA EFT: CORE 360 Uniform Use of CARC and RARC Rule - Update from CAQH CORE

MLN Matters® Number: MM9138
Related Change Request (CR) #: CR 9138
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3270CP
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9138 which instructs MACs and Medicare's Shared System Maintainers (SSMs) to update their systems based on the Council for Affordable Quality Healthcare (CAQH) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and RARC (835) Rule Set. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about June 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of Health and Human Services to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR9138 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 1, 2015. This update is based on March 1, 2015 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the WPC website.

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

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

Additional Information

The official instruction, CR9138 issued to your MAC regarding this change is available on the CMS website.

MREP Upgrade

MLN Matters® Number: MM9203
Related Change Request (CR) #: CR 9203
Related CR Release Date: August 6, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R1524OTN
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9203. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare & Medicaid Services (CMS) to help providers transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR9203 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. The key change in this latest version of the software is an enhancement to the MREP application to suppress the PR group code (Patient Responsibility) from the glossary of the Entire Remittance Report when the only Patient Responsibility items on the claim are for Claim Adjustment Reason Code (CARC) 01 (deductible) and CARC 02 (co-insurance). Make sure that your billing staffs are aware of these changes.

Additional Information

The official instruction, CR9203 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1524OTN.pdf on the CMS website.

More details about the free software, including instructions for downloading the software, are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html on the CMS website.

Phase III ERA EFT: CORE 360 Uniform Use of CARC and RARC Rule - Update from CAQH CORE

MLN Matters® Number: MM9270
Related Change Request (CR) #: CR 9270
Related CR Release Date: August 21, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3335CP
Implementation Date: January 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9270 instructs MACs to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2015.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set, required by January 1, 2014, by the Affordable Care Act.

CR9270 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2015. This update is based on July 1, 2015 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website. (Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.)

Additional Information

The official instruction, CR9270 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3335CP.pdf on the CMS website.

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9278
Related CR Release Date: August 6, 2015
Related Transmittal #: R3298CP
Change Request (CR) #: CR 9278
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Change Request (CR) 9278 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers. Make sure that your billing staffs are aware of these updates.

Background

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

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. If any new or modified code has an effective date past the implementation date specified in CR9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR9278 lists only the changes that have been approved since the last code update by CR9125 issued on April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at http://www.wpc-edi.com/Reference on the WPC website.

Changes in RARC List Since CR9125

New Codes – RARC

Code	Modified Narrative	Effective Date
N753	Missing/Incomplete/Invalid Attachment Control Number.	07/01/2015
N754	Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.	07/01/2015
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	07/01/2015
N756	Missing/Incomplete/Invalid point of drop-off address.	07/01/2015
N757	Adjusted based on the Federal Indian Fees schedule (MLR).	07/01/2015
N758	Adjusted based on the prior authorization decision.	07/01/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	07/01/2015

Modified Codes – RARC

Code	Modified Narrative	Effective Date
M47	Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	07/01/2015
MA74	ALERT: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	07/01/2015
N432	ALERT: Adjustment based on a Recovery Audit.	07/01/2015
N22	ALERT: This procedure code was added/changed because it more accurately describes the services rendered.	07/01/2015
M39	ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	07/01/2015
M109	ALERT: This claim/service was chosen for complex review.	07/01/2015
M38	ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	07/01/2015
N381	ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	07/01/2015
MA91	ALERT: This determination is the result of the appeal you filed.	07/01/2015

Deactivated Codes – RARC

Code	Current Narrative	Effective Date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	07/01/2016

***N735- This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.**

Changes in CARC List Since CR9125

New Code – CARC

Code	Modified Narrative	Effective Date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	07/01/2015

Modified Code – CARC

Code	Modified Narrative	Effective Date
45	Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. Note: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.)	11/01/2015

There have been no deactivated CARC codes since CR9125.

In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Additional Information

The official instruction, CR9278, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.pdf on the CMS website.

Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0470. The quarterly edit effectiveness results from January 2015 through April 2015 are as follows:

The E0470 review involved 26 claims, of which 14 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 50%.

The top denial reasons were:

- Insufficient documentation to meet basic coverage criteria.
- The order was signed after delivery.
- The documentation does not contain a valid date stamp or similar.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.

For complete details, see
Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review.

Correct Coding – Surgical Dressings Containing Unclassified Materials

DME MAC Joint Publication

Note: A previous version of this article was published in January 2015. The January publication was subsequently removed due to an inaccuracy in a reference to A9270. This article replaces that previous publication.

Some multi-component surgical dressings contain materials for which no specific HCPCS code exists. This article reviews the coding guidelines for these items.

Historically, materials not having specific HCPCS codes have not comprised the majority constituent(s) in multi-component products. Thus, these materials were not taken into consideration for HCPCS coding purposes. The longstanding coding guideline for multi-component dressings states that the clinically predominant component will determine classification. The current Surgical Dressings Local Coverage Determination (LCD) related Policy Article (PA) Coding Guidelines says:

> Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multi-component products may not be unbundled and billed as the separate components of the dressing.

Recently, multi-component dressings with non-classified (non-coded) components comprising the majority of the dressing's materials have been identified. The following clarification to the current guideline is being published in order to assure consistent interpretation of the "clinically predominant component" criterion. The revised coding guidelines clarify how products with non-coded materials are to be classified:

> Multi-component dressings that are not classified as composite dressings are categorized according to the clinically predominant component. The clinically predominant component is defined based on the proportion of material(s) in the dressing. For example, a dressing that is 60 percent hydrocolloid and 40 percent alginates would be categorized as a hydrocolloid dressing. HCPCS coding is determined based on the following:

- Products where a single material comprises greater than 50% (by weight) of a product's composition are coded based upon the applicable specific HCPCS code for that material. If a specific HCPCS code does not exist for the predominant component, HCPCS code A4649 (Surgical Supply, miscellaneous) is used.
- Products where no single material comprises greater than 50% (by weight) of the composition are coded as A4649 (Surgical Supply, miscellaneous).

The Surgical Dressings LCD related Policy Article Coding Guideline section will be updated to include this information.

Refer to the Surgical Dressing LCD and related PA for additional information about coding and coverage.

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

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

The quarterly edit effectiveness results from February 2015 through May 2015 are as follows:

The L7900 review involved 145 claims, of which 141 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **97%**.

The top reasons for denial were:

- Documentation does not support that the beneficiary has no evidence of symptomatic or untreated hypogonadism or hyperprolactinemia.
- Documentation does not support that the beneficiary had an in-person clinical evaluation with their treating physician within 6 months prior to ordering the item.
- Documentation does not support that other treatment options have been tried or considered and ruled out.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.

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

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