DME Happenings

Jurisdiction D
Issue No. 45
December 2014

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

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Noridian Healthcare Solutions, LLC

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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	1-888-826-5708	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

Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com/dme
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

2014 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.

Off-the-Phone Training	December 12, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 19, 2014	9:30 a.m. – 12 p.m. CT
Christmas	December 24, 2014	Entire Day Closed 8 a.m. – 6 p.m. CT
Christmas	December 25, 2014	Entire Day Closed 8 a.m. – 6 p.m. CT

Telephone Reopenings

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

Event	Date	Closure Timeframe
Off-the-Phone Training	December 12, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 19, 2014	9:30 a.m. – 12 p.m. CT
Christmas	December 24, 2014	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Christmas	December 25, 2014	Entire Day Closed 8 a.m. – 4:30 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.

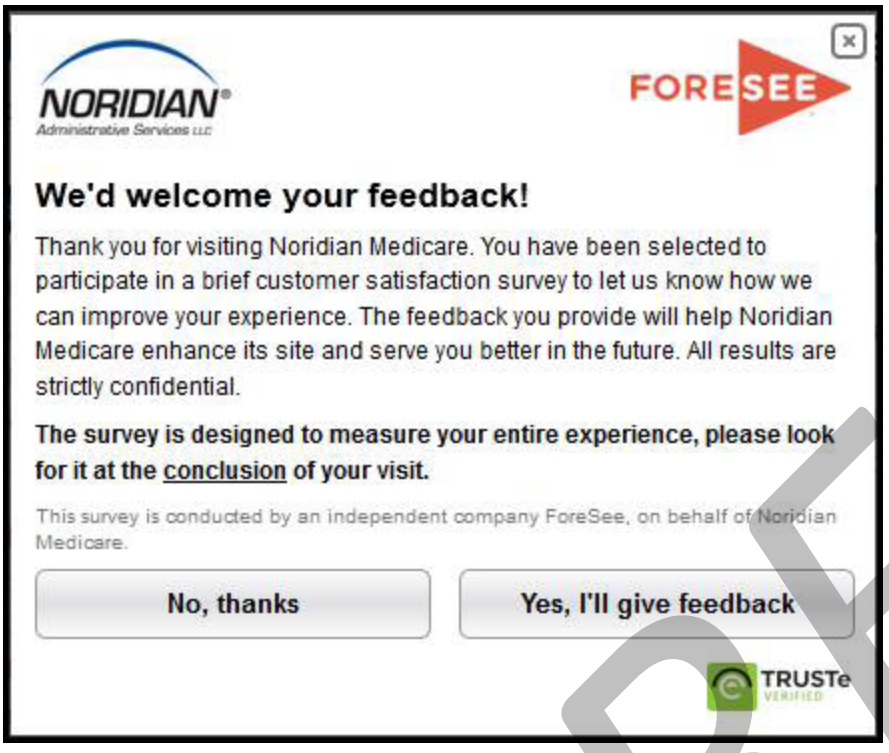
Feedback Requested – Noridian Customer Satisfaction Survey

Does the Noridian website and its specific elements address your needs? Are there things that you find very helpful while maybe other sections that you would like to see improved? With the many changes that we have made to better the Noridian website, we continue to seek your feedback. To ensure that we hear your best voice, please complete the ForeSee Results Survey that may pop up while browsing our website. Providing us with constructive and complimentary feedback is always helpful. Our site's continued growth is a key priority for us while serving our customers.

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."



After selecting "Yes, I'll give feedback," an additional pop-up box will display survey instructions. Once you have navigated away from the Noridian website, the survey will be presented to you for completion.

We appreciate your comments. It is your input that makes changes possible.

Sources for "Jurisdiction D Happenings" Articles

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

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

Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
13	Administrative Law Judge	Updated amounts in controversy for 2015	10/24/14
3	Orders	Added information in regards to PECOS	09/23/14
6	CMS-1500 Claim Form	Added information in regards to PECOS	09/23/14
3	Proof of Delivery	Added information on beneficiary's entering medicare	09/10/14

FYI

Transitioning MAC Workloads to New Banking Contractor

MLN Matters® Number: MM 8847
Related Change Request (CR) #: CR 8847
Related CR Release Date: September 19, 2014
Effective Date: September 19, 2014
Related CR Transmittal #: R240FM
Implementation Date: September 30, 2014

Provider Types Affected

This MLN Matters® Article is intended to alert all providers that your Medicare Administrative Contractor (MAC) may be transitioning their banking to another bank.

What You Need to Know

This article is informational in nature and is intended to inform you that Medicare has re-competed its banking contracts and has awarded two new five year contracts to US Bank (an incumbent bank) and to Citibank (which replaces the prior contract with JP Morgan Chase). The Centers for Medicare & Medicaid Services (CMS) awarded these new contracts on July 10, 2014. Change Request (CR) 8847 was issued to manage the transition of the MAC workloads from JP Morgan Chase to Citibank.

Background

In 2010, CMS changed its Medicare banking policies by discontinuing the use of time accounts to pay for banking service charges and awarded five year commercial services contracts through full and open competition to two banks (US Bank and JP Morgan Chase); these two banks disburse MAC authorized payments and Demonstration project payments for CMS. The two current commercial banking contracts are terminating in Fiscal Year 2015. CMS has awarded new five year contracts through full and open competition to US Bank (incumbent bank) and Citibank (new bank). Each selected bank shall provide both MAC payment services and Demonstration payment services and shall be designated Financial Agents of the U.S. Treasury.

CMS is transitioning MAC workloads from JP Morgan Chase to Citibank. The MAC workloads with US Bank will remain with US Bank. The transition began in August 2014 and will end in January 2015.

Additional Information

The official instruction for CR8847 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R240FM.pdf on the CMS website.

APPEALS

Telephone Reopenings: Resources for Success

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

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

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

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

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

What is not accepted as a Telephone Reopening?	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

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.

Claims Processing for Laboratory Services – Manual Update Clarification

MLN Matters® Number: MM8883
Related Change Request (CR) #: CR 8883
Related CR Release Date: September 19, 2014
Effective Date: December 22, 2014
Related CR Transmittal #: R3071CP
Implementation Date: December 22, 2014

Provider Types Affected

This MLN Matters® Article is intended for Medicare practitioners providing laboratory services to Medicare beneficiaries and billing Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare (DME) MACs for those services.

Provider Action Needed

Change Request (CR) 8883 updates the "Medicare Claims Processing Manual" to clarify that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance. The changes are intended to clarify the existing policies and no system or processing changes are anticipated. Make sure your billing staffs are aware of these policies.

Key Points

The manual updates, which are attached to CR8883, are as follows:

- The location where the independent laboratory performed the test determines the appropriate billing jurisdiction. If the sample originates in a different jurisdiction from where the sample is being tested, the claim must be filed in the jurisdiction where the test was performed.
- Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent laboratory, the specimen collection fee and travel allowance must be billed in conjunction with a covered laboratory test.
- The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

Additional Information

The official instruction, CR8883 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3071CP.pdf on the CMS website.

CMS 1500 Claim Form Instructions Version 02/12 - Revised

MLN Matters® Number: MM8509 Revised
Related Change Request (CR) #: CR 8509
Related CR Release Date: October 2, 2014
Effective Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10
Related CR Transmittal #: R3083CP
Implementation Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10

This article was revised on October 6, 2014, to reflect the revised CR8509 issued on October 2. In the article, the effective and implementation dates have changed and the CR release date, transmittal number and the Web address for accessing the CR are changed. All other information is the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare contractors (carriers, A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This change request (CR) 8509 revises the current CMS 1500 claim form instructions to reflect the revised CMS 1500 claim form, version 02/12.

Form Version 02/12 will replace the current CMS 1500 claim form, 08/05, effective with claims received on and after April 1, 2014:

- Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014;
- Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014;
- On April 1, 2014, Medicare will accept paper claims on only the revised CMS 1500 claim form, 02/12; and
- On and after April 1, 2014, Medicare will no longer accept claims on the old CMS 1500 claim form, 08/05.

Make sure that your billing staff are aware of these instructions for the revised form version 02/12.

Background

The National Uniform Claim Committee (NUCC) recently revised the CMS 1500 claim form. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

- DN – Referring Provider
- DK – Ordering Provider
- DQ – Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

The Administrative Simplification Compliance Act (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the CMS 1500 claim form. Medicare therefore supports the implementation of the CMS 1500 claim form and its revisions for use by its professional providers and suppliers meeting an ASCA exception. More information about ASCA exceptions can be found in Chapter 24 of the "Medicare Claims Processing Manual" which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information

The official instruction, CR 8509 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3083CP.pdf on the CMS website. CR 8509 contains the instructions for completing the revised CMS 1500 claim form (02/12), which will become part of Chapter 26 in the "Medicare Claims Processing Manual" (Pub. 100-04).

DMEPOS Fee Schedule – October 2014 Quarterly Update – Revised

MLN Matters® Number: MM8865 Revised
Related Change Request (CR) #: CR 8865
Related CR Release Date: November 13, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3123CP
Implementation Date: October 6, 2014

This article was revised on November 17, 2014, to reflect the revised CR8865 issued on November 13. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

Background

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

Key Points of CR8865

Splints, Casts, and Certain Intraocular Lenses (IOLs)
As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The 'IL" payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.

You may want to review MLN Matters® Article MM8645, "April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

Off-the-Shelf (OTS) Orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

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

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "Medicare Claims Processing Manual," Chapter 23, Section 60.3.1. at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Further information on the development of new OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

Specific Coding and Pricing Issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of Change Request 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

Additional Information

The official instruction, CR8865 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3123CP.pdf on the CMS website.

You may review Attachment B (page 19) of CR6270 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1630CP.pdf on the CMS website.

DMEPOS Fee Schedule – Update for 2015

MLN Matters® Number: MM8999
Related Change Request (CR) #: CR 8999
Related CR Release Date: November 21, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3129CP
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8999 to advise providers of the CY 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

Key Points

Fee Schedule Files

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

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

The following new codes are effective January 1, 2015:

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

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

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

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

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

Specific Coding and Pricing Issues
CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2013.

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

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

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

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

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

2015 Fee Schedule Update Factor of 1.5 Percent
For CY 2015, the update factor of 1.5 percent is applied to the applicable CY 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving

average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 Update to the Labor Payment Rates

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

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

STATE	K0739	L4205	L7520
AK	$27.98	$31.88	$37.50
AL	14.86	22.14	30.05
AR	14.86	22.14	30.05
AZ	18.37	22.11	36.97
CA	22.79	36.34	42.35
CO	14.86	22.14	30.05
CT	24.81	22.63	30.05
DC	14.86	22.11	30.05

STATE	K0739	L4205	L7520
NC	$14.86	$22.14	$30.05
ND	18.51	31.81	37.50
NE	14.86	22.11	41.90
NH	15.95	22.11	30.05
NJ	20.04	22.11	30.05
NM	14.86	22.14	30.05
NV	23.67	22.11	40.96
NY	27.35	22.14	30.05

STATE	K0739	L4205	L7520
DE	27.35	22.11	30.05
FL	14.86	22.14	30.05
GA	14.86	22.14	30.05
HI	18.37	31.88	37.50
IA	14.86	22.11	35.97
ID	14.86	22.11	30.05
IL	14.86	22.11	30.05
IN	14.86	22.11	30.05
KS	14.86	22.11	37.50
KY	14.86	28.34	38.43
LA	14.86	22.14	30.05
MA	24.81	22.11	30.05
MD	14.86	22.11	30.05
ME	24.81	22.11	30.05
MI	14.86	22.11	30.05
MN	14.86	22.11	30.05
MO	14.86	22.11	30.05
MS	14.86	22.14	30.05
MT	14.86	22.11	37.50

STATE	K0739	L4205	L7520
OH	14.86	22.11	30.05
OK	14.86	22.14	30.05
OR	14.86	22.11	43.21
PA	15.95	22.77	30.05
PR	14.86	22.14	30.05
RI	17.70	22.79	30.05
SC	14.86	22.14	30.05
SD	16.60	22.11	40.18
TN	14.86	22.14	30.05
TX	14.86	22.14	30.05
UT	14.90	22.11	46.79
VA	14.86	22.11	30.05
VI	14.86	22.14	30.05
VT	15.95	22.11	30.05
WA	23.67	32.44	38.53
WI	14.86	22.11	30.05
WV	14.86	22.11	30.05
WY	20.71	29.50	41.90
WY	20.71	29.50	41.90

2015 National Monthly Payment Amounts for Stationary Oxygen Equipment

As part of CR8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of

the new payment class for Oxygen Generating Portable Equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

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

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to Change Request (CR) 8566

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

Additional Information

The official instruction for CR8999 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3129CP.pdf on the CMS website.

HCPCS Codes for SNF CB – 2015 Annual Update

MLN Matters® Number: MM8943
Related Change Request (CR) #: CR 8943
Related CR Release Date: October 3, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3088CP
Implementation Date: January 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 & Hospice (HH&H) MACs and

Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. These edits allow separate payment for only those services that are excluded from consolidated billing (CB).

Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the "Medicare Claims Processing Manual," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf on the CMS website.

Additional Information

The official instruction, CR 8943, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3088CP.pdf on the CMS website.

Interventional Cardiology – New Physician Specialty Code – Second Revision

MLN Matters® Number: MM 8812 Revised
Related Change Request (CR) #: CR 8812
Related CR Release Date: September 23, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3073CP, R238FM
Implementation Date: January 5, 2015

This article was revised on September 26, 2014, to reflect the revised CR8812 that was issued on September 23. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

CR 8812, from which this article is taken, provides notice that the Centers for Medicare & Medicaid Services (CMS) is establishing a new physician specialty code for Interventional Cardiology. The CR is also changing the description of specialty code 62, and updating the names associated to specialty codes 88 and 95. Make sure your billing staffs are aware of these changes.

Background

Physicians who enroll in the Medicare program self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or via the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Non-physician practitioners who enroll with Medicare are assigned a Medicare specialty code. These Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. They become associated with the claims that physician or non-physician practitioners submit; and are used by CMS for programmatic and claims processing purposes.

CR 8812 establishes a new physician specialty code for Interventional Cardiology (C3). CR8812 is also removing the word "Clinical" from the description of specialty code 62 (Psychologist (Billing Independently)), and is changing the description of specialty code 88 to "Unknown Provider," and of specialty code 95 to "Unknown Supplier". The changes to the descriptions for codes 88 and 95 align their names with their intended usages.

Additional Information

The official instruction, CR 8812 issued to your MAC regarding this change is available in 2 transmittals at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3073CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R238FM.pdf on the CMS website.

Medicare Deductible, Coinsurance, and Premium Rates for 2015

MLN Matters® Number: MM 8982
Related Change Request (CR) #: CR 8982
Related CR Release Date: November 21, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R89GI
Implementation Date: January 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 & Hospice MACs and Durable Medical Equipment MACs, for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new Calendar Year (CY) 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

2015 PART A – HOSPITAL INSURANCE (HI)

- Deductible: $1,260.00
- Coinsurance:
  - $315.00 a day for 61st-90th day

- $630.00 a day for 91st-150th day (lifetime reserve days)
- $157.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)

- Base Premium (BP): $407.00 a month
- BP with 10% surcharge: $447.70 a month
- BP with 45% reduction: $224.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45% reduction and 10% surcharge: $246.40 a month

2015 PART B – SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- Standard Premium: $104.90 a month
- Deductible: $147.00 a year
- Pro Rata Data Amount:
  - $114.99 1st month
  - $32.01 2nd month
- Coinsurance: 20 percent

Additional Information

The official instruction, CR 8982, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R89GI.pdf on the CMS website.

New IUR Process for DME Items Furnished during a Part A Inpatient Stay

MLN Matters® Number: MM8844
Related Change Request (CR) #: CR 8844
Related CR Release Date: November 6, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R1435OTN
Implementation Date: April 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for hospitals and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for DMEPOS items provided to Medicare beneficiaries while an inpatient in an inpatient facility, or other facility.

Provider Action Needed

Change Request (CR) 8844 is a modification of CR8172 that gave providers guidance regarding the Centers for Medicare & Medicaid Services (CMS) longstanding edits in place to deny claims for DME items furnished during an inpatient stay. CR8172 only addressed Prosthetics and Orthotics and did not include DME. In addition, CR8172 provided instructions for the date of service through discharge date, but did not include day of discharge.

CR8844 provides a modification to include DME and discharge date to the Informational Unsolicited Response (IUR) edit process for DME during a Part A Inpatient Stay. Effective April 1, 2015, Medicare's Common Working File (CWF) will update the existing 7201 IUR edit to trigger recoupment for DME items furnished while the beneficiary was in a hospital inpatient stay. Make sure your billing staffs are aware of these changes.

Background

Section 1861(n) of the Social Security Act limits Part B coverage under the DME benefit to those items that are furnished for use in a patient's home. Inpatient facilities, and other facilities, may not be considered the patient's home. Therefore, payment for DME items may not be made while the beneficiary is in an inpatient

facility, or other facility. This applies to the following Healthcare Common Procedure Coding System (HCPCS) categories:

- 01 – Capped Rental DME;
- 02 – Frequently maintained DME;
- 04 – Inexpensive and routinely purchased DME;
- 05 – Electric Wheelchairs;
- 06 – Oxygen equipment; and
- 07 – Oxygen Supplies.

This does not apply when the DME claim has a patient status code of 03 or 83 AND the Skilled Nursing Facility (SNF) claim is not on file. Also, the edit will not apply if the "From" date of the DME claim is the same as an inpatient discharge date and the patient status code on the inpatient claim is 01 (Discharged to home or self-care), 06 (Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care), 50 (Discharged/transferred to Hospice - home), 81 (Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission), or 86 (Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission).

CMS has edits in place to deny claims for DME items furnished during an inpatient stay. Currently, however, no process is in place to recoup funds for DME items when the bill for the inpatient stay is received after the DME claim.

Effective April 1, 2015, CMS is creating a new IUR process within the CWF to identify DME claims that overlapped a Part A inpatient stay. An IUR identifies a claim that needs to be adjusted by the Medicare Administrative Contractor (MAC). The MAC will receive information from CWF as a result of the IUR, and initiate, when appropriate, the recoupment process for DME items furnished during an inpatient stay.

When your MAC denies a claim for DME when the beneficiary is in an inpatient stay, the denial will include the following remittance codes:

- Reason Code 96 – Non covered charge(s)
- Remark Code M18 – Certain Services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home
- Group Code PR – Patient Responsibility

Additional Information

The official instruction, CR8844 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1435OTN.pdf on the CMS website.

NPI and PTAN Differences – Revised

MLN Matters® Number: SE1216 Revised

This article was revised on September 5, 2014, to add the "Where Can I Find My PTAN?" section on page 3. All other information is the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What You Need to Know

This article explains the difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). There are no policy changes in this article.

Background

New Enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare Administrative Contractor (MAC), the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National Provider Identifier (NPI)

The NPI is a **national** standard under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render health care or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website.

Provider Transaction Access Number (PTAN)

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc.
- The PTAN's use should generally be limited to the provider's contacts with their MAC.

Where can I find my PTAN?

You can find your PTAN by doing any one of the following:

1. View the letter sent by your MAC when your enrollment in Medicare was approved.
2. Log into Internet-based PECOS. Click on the "My Enrollments" button and then "View Enrollments". Locate the applicable enrollment and click on the "View Medicare ID Report" link which will list all of the provider or supplier's active PTANs in one report.

3. The provider (or, in the case of an organizational provider, an authorized or delegated official) shall send a signed written request on company letterhead to your MAC; include your legal name/legal business name, national provider identifier (NPI), telephone and fax numbers.

Relationship of the NPI to the PTAN
The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain& Ownership System (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS
All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use internet-based PECOS: Log on to internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS website.
- Use the Paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- Note: The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)," provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf on the CMS website.

Additional Information

MLN Matters® Special Edition Article SE1126 titled "Further Details on the Revalidation of Provider Enrollment Information," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf on the CMS website.

"Medicare Provider–Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare Fee-For-Service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare Program and maintain their enrollment information. This resource is available at http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf on the CMS website.

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.

CERT

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.

CMS MLN CONNECTS ENEWS

MLN Connects Provider eNews

September 4, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- CMS Offers Settlement to Acute Care Hospitals and CAHs for Resolving Patient Status Denials – Register Now
- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs – Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript
- Providers and Suppliers – Browse the MLN Connects™ Call Program Collection of Resources

Announcements

- Get Ready for DMEPOS Competitive Bidding – Get Accredited
- Healthy Aging® Month – Discuss Preventive Services with your Patients
- New CMS Rule Allows Flexibility in Certified EHR Technology for 2014
- Open Payments System Outages

MLN Educational Products

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports" Educational Tool – Released
- "Intravenous Immune Globulin (IVIG) Demonstration - Implementation" MLN Matters® Article – Revised
- "Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised
- "Medicare Vision Services" Fact Sheet – Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet – Revised
- New MLN Provider Compliance Fast Fact
- MLN Products Available in Electronic Publication Format

September 11, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs – Last Chance to Register

Announcements

- Hospitals Appeals Settlement FAQs
- National Cholesterol Education Month – Medicare Preventive Services for Cardiovascular Disease
- New Release of PEPPER for Short-term Acute Care Hospitals
- EHR Incentive Programs: Learn More about Patient Electronic Access Requirements
- EHR Incentive Programs: Exclusions and Hardship Exceptions for Broadband Access

Claims, Pricers, and Codes

- Incarcerated Beneficiary Update
- Updated Information on Preventive Services Paid Based on the RHC or FQHC All-Inclusive Rate
- October 2014 Average Sales Price Files Now Available

MLN Educational Products

- "HIPAA Privacy and Security Basics for Providers" Fact Sheet – Released
- "The CMS Physician Quality Reporting System (PQRS) Program: What Medicare Eligible Professionals Need to Know in 2014" Web-Based Training Course – Released
- "The CMS Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014" Web-Based Training Course – Released
- "The Medicare and Medicaid EHR Incentive Programs: What Medicare and Medicaid Providers Need to Know in 2014" Web-Based Training Course – Released
- "Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" MLN Matters® Article – Revised
- "Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: Automation of the Request for Reopening Claims Process" MLN Matters® Article – Revised
- New MLN Topic of the Month

September 18, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- Hospital Appeals Settlement Update – Registration Opening Soon
- Transitioning to ICD-10 – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting

Announcements

- New Affordable Care Act Tools and Payment Models Deliver $372 Million in Savings, Improve Care
- HHS Provides Additional Flexibility for Certification of Electronic Health Record Technology
- Medicare EHR Incentive Program: October 3 Last Day for 1st-year EPs to Begin 2014 Reporting Period

Claims, Pricers, and Codes

- Mass Adjustments to IPF Claims with Teaching Adjustment Amounts Being Duplicated

MLN Educational Products

- "2014-2015 Influenza (Flu) Resources for Health Care Professionals" MLN Matters® Article – Released
- "Internet-based PECOS FAQs" Fact Sheet – Released
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet – Released
- "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet – Revised
- "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" Fact Sheet – Revised
- MLN Products Available In Electronic Publication Format

September 25, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings - Registration Opening Soon
- Hospital Appeals Settlement Update - Registration Now Open
- Transitioning to ICD-10 - Register Now
- New MLN Connects™ National Provider Call Video Slideshow

Announcements

- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- National Partnership to Improve Dementia Care Exceeds Goal to Reduce Use of Antipsychotic Medications in Nursing Homes: CMS Announces New Goal
- Hospital Appeals Settlement: New FAQs Posted
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- 2014 PQRS 2nd Quarter Interim Feedback Dashboard Reports Available
- 2013 PQRS and eRx Incentive Program Incentive Payments Available

- 2013 PQRS and eRx Incentive Program Feedback Reports Available
- 2012 eRx Incentive Program and 2012 PQRS Supplemental Incentive Payments Available
- Completion and Submission Timeframes for Hospice Item Set Records
- Important Skill Sets for Doctors and Nurses: CME Articles Available on Medscape
- New Resources and Webinars from National Health IT Week
- PQRS: New Quality Reporting Training Modules to Help Ensure Satisfactory 2014 Reporting
- 2014 CAHPS for PQRS Survey
- New PQRS FAQs Available
- New and Updated FAQs for the EHR Incentive Programs

Claims, Pricers, and Codes

- FDG PET for Solid Tumor Claims

Medicare Learning Network® Educational Products

- "Medicare Billing Information for Rural Providers and Suppliers" Booklet – Revised
- "Rural Health Clinic" Fact Sheet – Revised
- "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Fact Sheet – Revised
- "Critical Access Hospital" Fact Sheet – Revised
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

October 2, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings – Last Chance to Register
- Hospital Appeals Settlement Update – Last Chance to Register
- Overview of the 2013 Quality and Resource Use Reports - Registration Opening Soon
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Star Ratings on Dialysis Facility Compare

Announcements

- National Breast Cancer Awareness Month
- CMS Makes First Wave of Drug and Device Company Payments to Teaching Hospitals and Physicians Public
- Get Ready for DMEPOS Competitive Bidding – Common Ownership and Common Control
- PQRS GPRO Registration Extended Until October 3
- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- Comply with MAC Request for Fingerprints within 30 Days

- CMS Announces Availability of 2013 Quality and Resource Use Reports
- EHR Incentive Program: CMS Attestation System Open
- ICD-10 Compliance Date Is October 1, 2015

Claims, Pricers, and Codes

- ICD-10-CM Official Guidelines for Coding and Reporting Available

Medicare Learning Network® Educational Products

- "Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision" Fact Sheet – Revised
- "Medicare Appeals Process" Fact Sheet – Revised
- Medicare Learning Network® Products Available In Electronic Publication Format
- New Medicare Learning Network® Provider Compliance Fast Fact

October 9, 2014

View this edition as a PDF

In This Edition**:**

MLN Connects™ National Provider Calls

- Overview of the 2013 Quality and Resource Use Reports – Registration Now Open
- CMS 2014 Certified EHR Technology Flexibility Rule – Registration Now Open
- Transitioning to ICD-10 – Register Now

MLN Connects™ Videos

- Monthly Spotlight: Physician Quality Reporting System

Announcements

- CMS Announces Two Medicare Quality Improvement Initiatives
- New Outreach & Education Page at CMS.gov
- Work with Older Adult Patients? New Medscape Video for CME Credit
- Electronic Funds Transfer Upgrades to the Internet-based PECOS System
- Open Payments: Know the Numbers and Decode the Data
- CMS is Accepting Suggestions for Potential PQRS Measures
- PQRS: Physician Compare 2013 Group Practice Quality Measure Preview Period through November 7
- New FAQs for PQRS
- EHR Incentive Programs: Hardship Exception Applications to Avoid 2015 Payment Adjustment due November 30
- EHR Incentive Programs: Eligible Hospitals and Requirements for CEHRT to Participate in 2015
- EHR Incentive Programs: Learn How to Report 2014 eCQMs through the QualityNet Portal

Medicare Learning Network® Educational Products

- "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet – Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

October 16, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- Hospital Appeals Settlement Update 2 – Registration Opening Soon
- Overview of the 2013 Quality and Resource Use Reports – Last Chance to Register
- CMS 2014 Certified EHR Technology Flexibility Rule – Register Now
- Transitioning to ICD–10 – Register Now

MLN Connects™ Videos

- New Videos on ICD–10: Medicare Testing Plans and Home Health Conversion
- Did You Miss the Hospital Appeals Settlement Video?

Announcements

- Proposed Rule on Conditions of Participation for HHAs – Comments due December 8
- Get Ready for DMEPOS Competitive Bidding
- Cutting–edge Colorectal Cancer Screening Now Covered

Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hold on FQHC Medicare Advantage PPS Claims

Medicare Learning Network® Educational Products

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance

October 23, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- CMS 2014 Certified EHR Technology Flexibility Rule – Last Chance to Register
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Webinar for Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds

Announcements

- Protect Your Patients Against Influenza and Pneumonia
- Updated CDC Resource Available on Ebola
- New Affordable Care Act Initiative to Support Care Coordination Nationwide
- Extension of Shared Savings Program Fraud and Abuse Waivers Interim Final Rule
- IRF Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- LTCH Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- Open Payments Search Tool Now Available

- Open Payments: Start Preparing for the 2014 Reporting Year
- Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds
- EHR Incentive Programs: Protect Electronic Health Information Core Objective

Claims, Pricers, and Codes

- FQHC PPS Issue with Claims Containing Both Preventive and Non-Preventive Services
- Hold on FQHC Medicare Advantage PPS Claims – Update
- Use of HCPCS X Modifiers for Distinct Procedural Services
- Mass Adjustment of Selected SNF Inpatient Claims
- October 2014 Outpatient Prospective Payment System Pricer File Update

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 1]" Educational Tool – Released
- Medicare Learning Network® Web-Based Training Programs
- Updated MLN Matters® Search Indices

October 30, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- Transitioning to ICD-10 – Last Chance to Register

Announcements

- HHS Secretary Announces $840 Million Initiative to Improve Patient Care and Lower Costs
- Hospital Appeals Settlement: Act by October 31
- Get Ready for DMEPOS Competitive Bidding
- SNF PPS Payment Reform Research Project
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Third Quarter Hospice Item Set Question and Answer Document Available
- EHR Incentive Program: Hardship Exception Applications Due November 30
- PQRS: Submission Engine Validation Tool is Now Available for Testing

Claims, Pricers, and Codes

- Physicians, Providers, and Suppliers Must Use Revised CMS 855R Starting May 31
- Demand Letters for Polysomnography Claims

Medicare Learning Network® Educational Products

- "ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" – Revised
- "ICD-10-CM/PCS The Next Generation of Coding" – Revised
- "ICD-10-CM/PCS Myths and Facts" – Revised
- "ICD-10-CM Classification Enhancements" – Revised
- "General Equivalence Mappings Frequently Asked Questions" – Revised
- Medicare Learning Network® Web-Based Training Course with Continuing Education Credits
- Medicare Learning Network® Products Available in Electronic Publication Format

November 6, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Registration Opening Soon
- National Partnership to Improve Dementia Care in Nursing Homes – Registration Now Open
- Certifying Patients for the Medicare Home Health Benefit – Registration Opening Soon
- New MLN Connects™ National Provider Call Audio Recording and Transcript

MLN Connects™ Videos

- Monthly Spotlight: Medicare Preventive Services

Announcements

- CY 2015 Policy and Payment Changes to the Medicare Physician Fee Schedule
- CY 2015 Policy and Payment Changes for ESRD Facilities and Implementation of Competitive Bidding-Based Prices for DMEPOS
- CY 2015 Payment and Policy Changes for Hospital Outpatient and Ambulatory Surgical Centers
- CY 2015 Payment Changes for Medicare Home Health Agencies
- Raising Awareness of Diabetes in November
- Final Rule Changes for Open Payments
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- CMS is Accepting Suggestions for Potential PQRS Measures
- Comparative Billing Report on Modifier 25: Family Practice

Medicare Learning Network® Educational Products

- "Medicare Appeals Process" Podcast – New
- "Skilled Nursing Facility Prospective Payment System" Fact Sheet – Revised
- "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet – Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

November 13, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: November 17 through 21, 2014

Announcements

- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
- Dialysis Facility Compare Star Ratings and Data Release for January 2015
- Coverage of Speech Generating Devices
- Clinical Laboratory Improvement Amendments Proposed Rule
- PQRS Negative Payment Adjustment
- FY 2016 IRF Quality Reporting Program Submission Deadline: November 15
- FY 2016 LTCH Quality Reporting Program Submission Deadline: November 15
- OASIS Updates for Home Health Agencies
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Program: Deadlines for 2014 Hospital Reporting on November 30
- Changes to Medicare EHR Incentive Program Hardship Exceptions
- ICD-10 Resources for Small Physician Practices on Medscape

Claims, Pricers, and Codes

- ICD-10 MS-DRG v32 Definitions Manual and Medicare Code Editor Files Available
- 2015 HCPCS Annual Update
- Acute Inpatient PPS FY 2015.2 Software Release Available
- FDG PET for Solid Tumors: Claims Hold Extension

Medicare Learning Network® Educational Products

- "Safeguarding Your Medical Identity" Web-Based Training Course – Revised
- "Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised
- "Medicaid Program Integrity: Understanding and Preventing Provider Medical Identity Theft" Booklet – Revised
- "Medicaid Program Integrity: Preventing Provider Medical Identity Theft" Fact Sheet – Revised
- "Medicaid Program Integrity: Safeguarding Your Medical Identity Using Continuing Medical Education (CME)" Educational Tool – Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

November 20, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Register Now
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar – Registration Open

Announcements

- National Home Care and Hospice Month
- Seasonal Influenza and Diabetes Awareness
- Affordable Care Act and Health Care Coverage: CME Articles on Medscape
- Prior Authorization Process for Repetitive, Scheduled, Non-Emergent Ambulance Transport
- 2013 QRURs Available
- PEPPER Still Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Distribution of 2012 PQRS Supplemental Incentive Payments
- EHR Incentive Program: How to Report Once in 2014 for Medicare Quality Reporting Programs
- EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2

Medicare Learning Network® Educational Products

- The Medicare Learning Network® Autumn 2014 Catalog - Released
- "Revised Centers for Medicare & Medicaid Services (CMS) 855R Application – Reassignment of Medicare Benefits" MLN Matters® Article – Released
- "Medicare Billing: 837I and Form CMS-1450" Fact Sheet – Revised
- "Medicare Billing: 837P and Form CMS-1500" Fact Sheet – Revised
- "Evaluation and Management Services Guide" Educational Tool – Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Product Available in Electronic Publication Format

November 26, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Register Now

CMS Events

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar – Reminder

Announcements

- In Observance of World AIDS Day – Remember HIV Screenings
- CMS Creates New Chief Data Officer Post
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Programs: Hardship Exception Applications due November 30
- New EHR Attestation Deadline for Eligible Hospitals: December 31

Claims, Pricers, and Codes

- Hospice Notices Returned to Provider
- MA Claims Issue for FQHCs that Bill Under the AIR System

CMS MLN CONNECTS ENEWS

Medicare Learning Network® Educational Products

- "Hospice Related Services – Part B" Podcast - Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Submit Your Feedback on the Medicare Learning Network® Learning Management System and Product Ordering System
- Medicare Learning Network® Product Available in Electronic Format

CODING

Correct Coding – MyoPro® (Myomo, Inc.) Assist Device

Joint DME MAC/PDAC Publication

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated the MyoPro® upper extremity assist device and determined that it falls within the Durable Medical Equipment (DME) benefit category. Claims for MyoPro® should be submitted using the DME miscellaneous code E1399.

Suppliers are reminded that when submitting claims for items coded E1399, the supplier must include the following information:

- Manufacturer name
- Model name or number
- Pricing information
- Explanation of medical necessity

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.

This item is classified under the capped-rental payment methodology as it does not meet the requirements to be categorized as an inexpensive or routinely purchased item.

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

COMPETITIVE BIDDING

Quarterly Update for DMEPOS Competitive Bidding Program – April 2015

MLN Matters® Number: MM 8918
Related Change Request (CR) #: CR 8918
Related CR Release Date: November 26, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3136CP
Implementation Date: April 6, 2015
Provider Types Affected

This MLN Matters® Article is intended for DMEPOS suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for 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) 8918 to provide the DMEPOS Competitive Bidding Program (CBP) April 2015 quarterly update. CR 8918 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.

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 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

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

Additional Information

The official instruction, CR 8918 issued to your DME MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3136CP.pdf on the CMS website.

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

Quarterly Update for DMEPOS Competitive Bidding Program – October 2014 – Fourth Revision

MLN Matters® Number: MM 8676 Revised
Related Change Request (CR) #: CR 8676
Related CR Release Date: May 23, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2968CP
Implementation Date: October 6, 2014

This article was revised on October 16, 2014, to reference the correct HCPCS codes and to add a link to the Quarterly Update pages of the competitive bidding website in the "What You Need to Know" section. All other information remains the same.

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8676 to provide the DMEPOS Competitive Bidding Program (CBP) October 2014 quarterly update. CR 8676 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 posted to http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home on the Internet. At that site, click on the quarterly updates link in the left of the page.

ZIP Codes (Round 2 Only)

The following ZIP codes have been added to the Round 2 ZIP code files listed below to conform with U.S. Postal Service ZIP code changes within the identified competitive bidding areas:

- 97003 Portland-Vancouver-Beaverton, OR-WA
- 97078 Portland-Vancouver-Beaverton, OR-WA
- 20252 Washington-Arlington-Alexandria, DC-VA-MD-WV
- 56988 Washington-Arlington-Alexandria, DC-VA-MD-WV

The ZIP code files can be used to identify when a specific item furnished to a beneficiary is subject to the Competitive Bidding Program.

HCPCS Codes (Round 1 Recompete Only)

Effective January 1, 2014, the Round 1 Recompete Single Payment Amount file has been updated to replace HCPCS code, E0731NU, with HCPCS code, E0731NUKG. This change allows Medicare to accurately process and pay HCPCS code E0731 (Form Fitting Conductive Garment for Delivery of TENS or NMES (with Conductive Fibers Separated from the Patient's Skin by Layers of Fabric)) according to competitive bidding payment rules when used in conjunction with a competitive bidding base unit, such as a TENS device.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new CBP for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, the result being reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS conducted the supplier competition again in nine areas in 2009, referring to it as the Round One Rebid. The Round One Rebid contracts and prices became effective on January 1, 2011 in the nine areas.

MIPPA also delayed the competition for Round Two from 2009 to 2011 and authorized national mail order competitions after 2010. The Affordable Care Act of 2010 expanded the number of Round Two MSAs from 70 to 91 and specified that all areas of the country be subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The contracts and prices for Round 2 and the national mail-order program for diabetic testing supplies became effective on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except

mail-order diabetic supplies expired on December 31, 2013. (The Round One Rebid mail-order diabetic supply contracts expired on December 31, 2012.) On January 1, 2014, new contracts for the Round One Recompete became effective in the same competitive bidding areas as the Round One Rebid.

Additional Information

The official instruction, CR 8676 issued to your DME MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2968CP.pdf on the CMS website.

Quarterly Update for DMEPOS Competitive Bidding Program – January 2015

MLN Matters® Number: MM8907
Related Change Request (CR) #: CR 8907
Related CR Release Date: September 12, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3068CP
Implementation Date: January 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 DMEPOS provided to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8907 to provide the DMEPOS Competitive Bidding Program (CBP) January 2015 quarterly update. Change Request (CR) 8907 provides specific instructions for the DME MACs in implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new CBP for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards.

Under the MMA, the DMEPOS CBP was to be phased in so that competition under the program would first occur in 10 Metropolitan Statistical Areas (MSAs) in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made other limited changes. As required by MIPPA, CMS conducted the supplier competition in nine MSAs in 2009, referring to it as the Round 1 Rebid. The Round 1 Rebid contracts and prices became effective on January 1, 2011.

MIPPA also delayed the competition for Round 2 from 2009 to 2011 and authorized national mail-order competitions after 2010. The Affordable Care Act expanded the number of Round 2 MSAs from 70 to 91. Contracts and prices for Round 2 and the national mail order program for diabetic testing supplies went into effect on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS CBP at least once every three years. The Round 1 Rebid contract period for all product categories except mail-order diabetic supplies expired on December 31, 2013. (The Round 1 Rebid mail-order diabetic supply contracts expired on December 31, 2012.) CMS is conducting the Round 1 Recompete in the same competitive bidding areas as the Round 1 Rebid.

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

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

Additional Information

The official instruction for CR 8907 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3068CP.pdf on the CMS website.

Pub 100-03, Chapter 1, Language-only Update – Revised

MLN Matters® Number: MM 8506 Revised
Related CR Release Date: September 4, 2014
Related CR Transmittal #: R173NCD
Related Change Request (CR) #: CR 8506
Effective Date: Upon ICD-10 Implementation
Implementation: Upon ICD-10 Implementation

This article was revised on September 8, 2014, to reflect the revised CR8506 issued on September 4. The CR release date, effective and implementation dates, transmittal number, and the Web address for accessing the CR are revised. All other information is unchanged.

Provider Types

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8506 as an informational alert to providers that language-only changes - updates to the "Medicare National Coverage Determinations (NCD) Manual", Pub 100-03 - were made.

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

NOTE: The edits made to the NCD Manual are technical/editorial only and in no way alter existing NCD policies.

Background

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional Information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R173NCD.pdf on the CMS website.

ACA Requirement for Indicating Receipt Date of Documentation

Joint Article

With the implementation of Affordable Care Act (ACA) Section 6407, there are local coverage determinations (LCDs) and related policy articles (PAs) that require suppliers to receive clinical documentation and orders within a specific period of time. According to these LCDs, "A date stamp or equivalent must be used to document receipt date." Documentation of the receipt date is a key requirement of these policies to demonstrate compliance with the statutory timeliness requirement.

Questions have arisen from suppliers about what methods are acceptable for documenting a receipt date. 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 hard-copy date stamps, hand-written dates, facsimile headers and electronic receipt dates. 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.

A cautionary note about utilizing facsimile headers to document receipt date. Suppliers often rely on a fax header that includes a date and time indicator as an alternative to a date stamp. However, there are often multiple facsimile header lines that are the result of documents being faxed back and forth between the supplier and treating physician. Consequently, it is often difficult to determine the actual date of receipt of the documents by the supplier.

Suppliers should review their process for documenting the date of receipt of the documentation related to policies that requirement a receipt date. Suppliers must ensure that all documents clearly indicate the date that the documents were received. Suppliers who rely on fax header information should be especially vigilant to make sure that the receipt date is clearly indicated to avoid claim denials.

ADR Response – New Timeframe – Revised

MLN Matters® Number: MM 8583 Revised
Related Change Request (CR) #: CR 8583
Related CR Release Date: November 14, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R554PI
Implementation Date: April 6, 2015

This article was revised on November 18, 2014, to make corrections in the article, especially to clarify ADR requirements related to pre-payment review.

Provider Types Affected

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

What You Need to Know

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

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its

attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).

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

- The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.
- According to the "Medicare Program Integrity Manual," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions),when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

Additional Information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R554PI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Face-to-Face Requirements for Orders Used to Obtain Medicare Payment on ACA Items

Joint DME MAC Publication

The Affordable Care Act (ACA) Section 6407 requires a face-to-face encounter to occur within 6 months prior to the written order prior to delivery (WOPD) for certain DME items listed within it (see "MM8304 Revised - Detailed Written Orders and Face-to-Face Encounters"). This requirement applies any time a new order has been obtained for the purposes of Medicare payment. The only exception to the requirement for a face-to-face encounter within 6 months is when a new order is obtained due to state law, and the order is **not** being used as documentation to support a claim for Medicare payment. If the order is being used to meet a Medicare requirement, a new face-to-face must be conducted.

If a new order is being used as documentation to support continued medical need or to fulfill any other documentation requirement for Medicare payment, then a face-to-face encounter within 6 months prior would be required. One way to determine whether or not a new face-to-face encounter is required is to determine if the order obtained/required will be used to support Medicare payment of the claim. If the answer is "yes" then a face-to-face encounter is required within 6 months of the date prior to that order.

The face-to-face requirement became effective 7/1/13 for all ACA items and a delay in enforcement has been made by the DME MACs. Other auditing entities may enforce this requirement at this time.

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

Signature Credentials

Avoid unnecessary Comprehensive Error Rate Testing (CERT) denials by ensuring signatures on documentation include credentials.

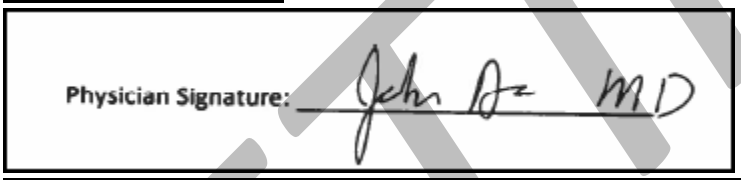
DOCUMENTATION

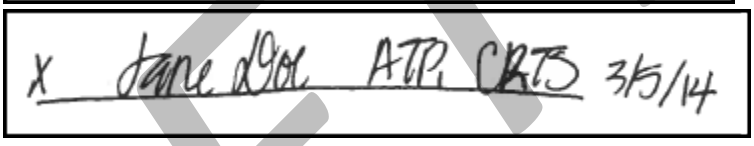
Credentials are an important part of any signature that appears on documentation submitted for Medicare review. Whether the review is for a MAC, CERT, Recovery Auditor, Zone Program Integrity Contractor (ZPIC) or any other Medicare review contractor, a signature must be identified with the proper credentials.

A credential is a group of letters that identifies what certificate the author holds. Some common examples include, but are not limited to the following; MD, RESNA, ATP, CPO, DO, NP, PA, RN, PT and OT.

Credential	Certification
MD	Medical Doctor
RESNA	Rehabilitation Engineering & Assistive Technology Society of North America
ATP	Assistive Technology Professional
CPO	Certified Prosthetist-Orthotist
DO	Doctor of Osteopathy
NP	Nurse Practitioner
PA	Physician Assistant
RN	Registered Nurse
PT	Physical Therapist
OT	Occupational Therapist

The below are examples of acceptable signatures with credentials for Medicare purposes:





Many Local Coverage Determination (LCD) policies have guidelines regarding the specific professional that may order DME or oversee beneficiary care. It is important for the supplier to review all signatures on documentation prior to submission to ensure the signature includes the proper credentialing.

A common CERT error a supplier may receive is, "documentation is missing a signature attestation and credentials for the clinic summary delivery note."

To avoid the above error, the supplier has the ability to review the claim documentation prior to submission to see that the signature was missing credentials. A recommendation would be for the supplier to reach out to the author and have the record amended or provide a valid signature attestation to be sent with the original documentation.

Another common error has to do with a RESNA certified employee who does not add their credentials following their signature. The CERT comment may state, "Documentation supporting the wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional."

This error would be simple to correct as the RESNA certified ATP works for the supplier. An amended signature or signature attestation are available options. The other alternative would be to send in a copy of the employee's RESNA ATP certification.

More information may be found in CMS Publication 100-08, Program Integrity Manual (PIM), Chapter 3.

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

Joint DME MAC Publication

Note: This is a revision to a previously article published in October 2014 entitled Standard Documentation Language for Local Coverage Determinations and related Policy Articles – Revised. This version adds information on repairs in the Policy Specific Documentation Section of the LCDs.

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

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

IMPORTANT

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

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

Standard Language

LCD

Coverage Indications, Limitations and/or Medical Necessity

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

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

DWO Verbiage

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

ACA WOPD (Editor Note: Insert after DWO section)

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

REFILL REQUIREMENTS (Editor Note: Use for those LCDs with continuous supplies
Remember to add matching refill documentation language (see below))

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6).

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

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

Documentation Requirements

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

Prescription (Order) Requirements

General (PIM 5.2.1)

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

Dispensing Orders (PIM 5.2.2)

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

- Description of the item
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

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

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

The dispensing order must be available upon request.

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

ACA 6407 (Prescription Requirements, prior to DWO)

Written Orders Prior to Delivery (PIM 5.2.3.1)

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

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

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

The DWO must be available upon request.

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

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

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

Medical Record Information

General (PIM 5.7 -5.9)

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

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

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

Continued Medical Need

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

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

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

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

Continued Use

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

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

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

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

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

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

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

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

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

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

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

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

Proof of Delivery (PIM 4.26, 5.8)
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

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

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

(Editor Note: Some LCDs only have 2 methods of delivery – Delete #3)
Suppliers are required to maintain POD documentation in their files. For items addressed in this policy there are three methods of delivery:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Method 1 – Direct Delivery to the Beneficiary by the Supplier
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

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

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

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

Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

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

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

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

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

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

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

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

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

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

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

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

Policy Specific Documentation Requirements

Affordable Care Act (ACA) 6407 Requirements
ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

{Insert code table}

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

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

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

General

Certificate of Medical Necessity (PIM 5.3) (Editor Note: Only for items requiring CMN)

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

(Editor Note: Add specific DIF instructions as needed)

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

DME Information Form (PIM 5.3) (Editor Note: Only for items requiring a DIF)
A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(Editor Note: Add specific DIF instructions as needed)

Repair/Replacement(BPM Ch 15, §110.2) (Editor Note: Applies to all DMEPOS except artificial limbs)
A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

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

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

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

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

Repair/Replacement (BPM Ch 15, §120) (Editor Note: Only applies to Lower Limb Prostheses LCD)
Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

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

- 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,
- An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
- The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

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

Miscellaneous

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

Appendices

PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-8

For the revision history of the LCD
DOCUMENTATION REQUIREMENTS:(Editor 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)

Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Policy Article

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

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

Or

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

Written Order Prior to Delivery (Editor Note: Only when WOPD required)
When the supplier is required to have a written order prior to delivery but bills an item without a detailed written order, the item will be denied as statutorily excluded.

Or for Drugs

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

Affordable Care Act (ACA) 6407 Requirements
ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

{Select codes from table below}

Face-to-Face Visit Requirements:

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

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

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

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

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

Prescription Requirements:

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

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

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

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

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

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

- Verify that the in-person visit occurred within the 6-months prior to the date of their prescription, and
- Have documentation of the face-to-face examination that was conducted, and
- Provide the DMEPOS supplier with copies of the in-person visit records.

Date and Timing Requirements

There are specific date and timing requirements:

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

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

is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

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

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

Coding Guidelines

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

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

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

Correct Coding – Oral Anticancer Drugs and PDAC's NDC/HCPCS Crosswalk Listings

Joint DME MAC Publication

Occasionally pharmaceutical manufacturers release drugs with National Drug Codes (NDCs) and they do not immediately appear on the NDC/HCPCS crosswalk list maintained by the Pricing, Data Analysis and Coding (PDAC) contractor (see article from April 2013 entitled "Oral Anticancer Drugs – Coding and Billing Change"). This recently happened when Roxane Laboratories, Inc., a manufacturer of oral cyclophosphamide, discontinued their tablet forms of the drug and substituted capsules. Initially the capsule forms of the drug (NDC 00054-0382-25 for the 25 mg strength and NDC 00054-0383-25 for the 50 mg strength) were not on the NDC/HCPCS crosswalk list. This list has now been updated to reflect the new dosage forms and NDC numbers for Roxane's cyclophosphamide.

If a supplier bills an oral anticancer drug with an NDC number that is not on the NDC/HCPCS crosswalk list, the claim will receive a front-end reject by CEDI. To avoid this situation, suppliers should follow the instructions in the Coding Guidelines section of the Oral Anticancer Drugs related Policy Article (PA) which states:

A list of valid NDC numbers called the "NDC/HCPCS Crosswalk" for covered oral anticancer drugs can be found on the Pricing, Data Analysis and Coding (PDAC) Contractor web site. Until a new NDC number is added to the list, suppliers must submit claims using code J8999.

Until a new NDC number is added to the list in the monthly update, suppliers have two options:

1. Hold claim submission until the NDC/HCPCS Crosswalk reflects the monthly update of covered OACDs; or,
2. Submit claims using code J8999.

Claims submitted using code J8999 must include the name of the drug, the manufacturer, the NDC number, the dosage strength of each drug form (e.g., capsule, tablet, suppository, liquid) and the number of tablets or capsules dispensed. 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.

The NDC/HCPCS Crosswalk files can be found on the PDAC website at https://www.dmepdac.com/crosswalk/index.html.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes J707, J7517, J7518 and J7520. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The J7507 review involved 4,552 claims, of which 3,322 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 68%.

The J7517 review involved 2,757 claims, of which 2,029 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 70%.

The J7518 review involved 1,618 claims, of which 1,120 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 65%.

The J7520 review involved 467 claims, of which 345 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 71%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- No refill request was submitted
- Proof of delivery (POD) submitted was invalid
- No POD was submitted

Going Forward

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

Educational Resources

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

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

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

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

Policy Education

No documentation was received in response to ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

No refill request was submitted.
For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/

contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

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

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

The POD submitted was either invalid or no POD was submitted for review.
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

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

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

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

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery
- If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

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

Method 3 – Delivery to Nursing Facility on Behalf of a Beneficiary
When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

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

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

Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Pricing Files – January 2015

MLN Matters® Number: MM8912
Related Change Request (CR) #: CR 8912
Related CR Release Date: September 19, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3072CP
Implementation Date: January 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) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8912 instructs Medicare Administrative Contractors (MACs) to download and implement the January 2015 Quarterly Average Sales Price (ASP) and, if released by the Centers for

Medicare & Medicaid Services (CMS), the revised October 2014, July 2014, April 2014, and January 2014, average sales price (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 January 5, 2015, with dates of service January 1, 2015, through March 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 that manufacturers submit to CMS. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, section 50, of the "Medicare Claims Processing Manual" which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website.

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

Files	Effective Dates of Service
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014

Additional Information

The official instruction, CR 8912 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3072CP.pdf on the CMS website.

EDUCATIONAL

2014 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 2014 ACT: 3 p.m. CT

Date	Topic
July 15, 2014	Orthotics & Prosthetics
September 18, 2014	Appeals
November 20, 2014	Respiratory
January 29, 2015	General

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

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

DME On Demand

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

Glucose Monitors and Supplies: Coverage Criteria

- NMO
- Coverage Criteria
- Special Feature Items
- Accessories and Supplies
- Noncovered Supplies
- Usual Utilization Guidelines
- Resources

Glucose Monitors and Supplies: Documentation Requirements

- Documentation
- Preliminary/Dispensing Order
- Detailed Written Order Elements
- Medical Records
- Continued Use/Need
- Refill Documentation
- Resources

Glucose Monitors and Supplies: Overutilization, Upgrades and Billing

- Utilization
- Modifiers
- Upgrades
- Spanning Dates of Service
- Bundling
- Resources

Orthopedic Footwear

- Coverage and Payment Rules
- Coding Guidelines
- Documentation
- Modifiers
- Prosthetic Shoes
- Resources

PMD: Advance Determination of Medicare Coverage (ADMC) vs. Prior Authorization Request (PAR)

- Submitting an ADMC or PAR
- Determining ADMC or PAR
- PMD Resources
- Additional Resources

PMD – Face-to-Face and 7-Element Order

- 7-Element Order
- LCMP Report
- 45 day Requirement
- Face-to-Face Completed by Physician
- LCMP Prior to Physician Face-to-Face
- Physician Face-to-Face
- Exam While Inpatient
- Resources

PMD: Home Assessment

- Resources
- LCD
- Home Assessment
- Documentation
- When to Submit
- Examples

PMD PAR – Beneficiary Change of Address

- Reference Chart
- Demonstration States
- Supplier/Jurisdiction Scenarios
- Resources

PMD PAR – Demonstration and Expansion

- Background Information
- PMDs Included
- Where
- Benefit
- Effective Dates
- Changes
- Resources

PMD PAR – Scenarios

- Scenarios
  - PAR Submitted
  - PAR Not Submitted
  - 25% Reduction
- Resubmitting a PAR
- Resources

PMD PAR – Submitting a PAR

- PAR Content
- PAR Coversheet
- Submit PAR
- Resources

Power Mobility Devices – Documentation

- Process
- Documentation
- Face-to-Face Examination
- Face-to-Face Element
- LCMP
- Specialty Evaluations
- Valid 7-Element Order
- Detailed Product Description
- Resources

Viewing Presentations

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

Upcoming 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 2014 ACT: 3 p.m. CT

Date	Topic
January 29, 2015	General

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

View previous ACT questions and answers at https://www.noridianmedicare.com/dme/train/act/act_schedule.html.

Endeavor Multiple NPI Request Form

Suppliers who conduct inquiries in Endeavor for additional National Provider Identifiers (NPIs) are encouraged to use the updated Multiple NPI Request Form. Suppliers requesting access to multiple NPIs must have at least one NPI listed on their existing account in order to use this form.

Benefits of using this form include:

- Elimination of duplicate NPI registrations
- Faster processing of the requests by Noridian staff members
- More convenient, fillable PDF form compared to online NPI addition entry within Endeavor
- Avoids system delays while entering multiple NPIs in the Administration Options feature of Endeavor

Noridian has updated the Multiple NPI Request form that now requires the last five digits of the Tax Identification Number (TIN) and Unique Identification Number (UIN). The required information is used to authenticate the user requesting access to additional NPIs. The multiple NPI request form is located on our Endeavor page under Forms. To access the form go to https://www.noridianmedicare.com/dme/claims/endeavor/multiple_npi_request.pdf.

Endeavor Multiple User ID Consolidation Request Form

Suppliers with multiple Endeavor accounts should request their accounts be consolidated into one. Users should not have more than one account. Multiple National Provider Identifiers (NPIs) with different Tax Identification Numbers (TINs) are allowed on the same account.

Users are asked to provide the following information on the form:

- User ID (the one you want to stay active)
- User IDs to be decommissioned after consolidation
- NPI
- Tax ID
- Unique Identification Number (UIN)

The Endeavor Multiple User ID Consolidation Request Form is located on our Endeavor page under Forms. To access the form go to https://www.noridianmedicare.com/dme/claims/endeavor/multiple_user_id_consolidation_request.pdf.

Endeavor Tutorials Available

Self-paced tutorials on the functions of Endeavor are now available on the Endeavor website: https://www.noridianmedicare.com/dme/claims/endeavor.html. The tutorials provide step-by-step instructions, screen images for visual guidance, and tips and reminders. The tutorials range from two to eight minutes in length.

The following tutorials are available:

- Eligibility
- Claim Status
- Appeal Submission
- Financial
- DME Overpayments
- Power Mobility Device (PMD) Prior Authorization Request (PAR) Status
- Claim-Specific Remittance Advice

Noridian encourages suppliers to share feedback regarding Endeavor: http://www.surveygizmo.com/s3/1802173/NHS-Endeavor-Survey-041411.

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

The Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes B4185 and B4197. This review was initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

The B4185 review involved 98 claims, of which 73 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 76%.

The B4197 review involved 92 claims, of which 72 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation did not support coverage criteria
- Detailed written order (DWO) was incomplete and/or missing elements
- Refill documentation was incomplete and /or missing elements

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS codes B4195 and B4197.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Parenteral Nutrition Local Coverage Determination (LCD) L11576 and Policy Article A37077.

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

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

Policy Education

No documentation was received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Documentation submission information in response to ADR letters can be found in the claims section on the Noridian website.

Documentation did not support coverage criteria.

Maintenance of weight and strength commensurate with the beneficiary's overall health status must require intravenous nutrition and must not be possible utilizing all of the following approaches:

- Modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, provision of protein as peptides or amino acids, etc.), and
- Utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, etc.)

Parenteral nutrition is covered in any of the following situations:

- The beneficiary has undergone recent (within the past 3 months) massive small bowel resection leaving less than or equal to 5 feet of small bowel beyond the ligament of Treitz, or
- The beneficiary has a short bowel syndrome that is severe enough that the beneficiary has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters/day the enteral losses exceed 50% of the oral/enteral intake and the urine output is less than 1 liter/day, or
- The beneficiary requires bowel rest for at least 3 months and is receiving intravenously 20-35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula isn't possible, or
- The beneficiary has complete mechanical small bowel obstruction where surgery is not an option, or
- The beneficiary is significantly malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has very severe fat malabsorption (fecal fat exceeds 50% of oral/enteral intake on a diet of at least 50 gm of fat/day as measured by a standard 72 hour fecal fat test), or
- The beneficiary is significantly malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl) and has a severe motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication and is demonstrated either:
- Scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon by 6 hours following ingestion), or
- Radiographically (barium or radiopaque pellets fail to reach the right colon by 6 hours following administration). These studies must be performed when the beneficiary is not acutely ill and is not on any medication which would decrease bowel motility.

Unresponsiveness to prokinetic medication is defined as the presence of daily symptoms of nausea and vomiting while taking maximal doses.

For the criteria menioned above, the conditions are deemed to be severe enough that the beneficiary would not be able to maintain weight and strength on only oral intake or tube enteral nutrition.

Beneficiaries who do not meet the criteria above must meet modification of diet and pharmacologic intervention, plus the following:

- The beneficiary is malnourished (10% weight loss over 3 months or less and serum albumin less than or equal to 3.4 gm/dl), and
- A disease and clinical condition has been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).

DWO was incomplete and/or missing elements.
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.

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

- Description of the item
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

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

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

The dispensing order must be available upon request.

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

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

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

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

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

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

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

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

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

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

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

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies, i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) – the supplier should assess the quantity of each item that the beneficiary still has remaining, to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.

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

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

The B4150 review involved 1,520 claims, of which 1,179 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 74%.

The B4154 review involved 1,232 claims, of which 967 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 66%.

Top Denial Reasons

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

Going Forward

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

Educational Resources

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

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

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

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

Policy Education

No documentation received in response to ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

Detailed Written Order (DWO) was incomplete or missing required elements.
A DWO is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

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

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

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

Refill request was incomplete/missing required elements or no refill request was submitted.
For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

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

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

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

Proof of Delivery (POD) submitted was invalid.
Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Method 1 – Direct Delivery to the Beneficiary by the Supplier
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery
- If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

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

Method 3 – Delivery to Nursing Facility on Behalf of a Beneficiary
When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

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

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

Coverage Reminder – External Infusion Pumps, Supplies, and Drugs

Joint DME MAC Publication

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

Reasons For Denial

- Prescriptions
  - Physician's detailed written order is missing, incomplete, or invalid – 29%
- DME Information Form (DIF)
  - Missing DIF – 26%

- Reasonable & Necessary (R&N)
  - Local Coverage Determination (LCD) Coverage Criteria not met – 39%
- Other
  - Continued Need Criteria not met – 3%
  - Unsigned Clinical Notes – 3%

Payment Rules

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

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS code E0784, as specified in the table contained in the Policy Specific Documentation Requirements Section of the LCD for External Infusion Pumps (EIP) LCD L11570. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO **before** dispensing the item.

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

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

Reasonable and Necessary (R&N) Criteria:
This policy covers numerous drugs, and suppliers and providers are encouraged to review the specific coverage requirements for the relevant drug in question. In general, external infusion pumps and related drugs and supplies will be denied as not reasonable and necessary when the criteria described by indication (I), (II), (III), (IV) or (V) in LCD L11570 are not met. When an infusion pump is covered, the drug necessitating the use of the pump and necessary supplies are also covered.

When a pump has been purchased by the Medicare program, other insurer, the beneficiary, or the rental cap has been reached, the drug necessitating the use of the pump and supplies is covered as long as the coverage criteria for the pump are met.

Drugs are only covered as a supply to a covered DME infusion pump. Drugs billed alone (without a covered pump being used) will be denied as statutorily noncovered (no benefit).

Continued Medical Need:
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:

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

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

Documentation

In the event of a claim review:

- Medicare requires that there is a prescription (order) for every separately billable item.
- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements are met.

This article presents a summary of the policy requirements related to the errors identified in the CERT reviews. The majority of reasons for CERT errors (55%) are completely within the purview of suppliers. Thus, suppliers are encouraged to review their claim submission practices, in order to begin to reduce the high level of CERT errors. There are additional requirements necessary for coverage that are not discussed in this article. Please refer to the LCD L11570 and related Policy article for complete information. Further education regarding this policy is available on your DME MAC contractor website.

GLUCOSE MONITORS

Blood Glucose Test or Reagent Strips (HCPCS A4253KS) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code A4253KS. The quarterly edit effectiveness results from April 2014 through June 2014 are as follows:

> The A4253KS review involved 2657 claims, of which 2626 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 94%.

Top Denial Reasons

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

Going Forward

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

Educational Resources

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

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

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

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

Policy Education

No physician's medical office records were received.

Documentation Requirements

> Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided.

The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

General (PIM 5.7–5.9)
The Nonmedical Necessity Coverage and Payment Rules section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.
- Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

Documentation submitted did not support the specific reason for the additional supplies.
For services performed on or after 11/01/12 **– (**Criterion B for high utilization) - The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary.

Documentation submitted did not support the actual testing frequency that corroborates with the quantity of supplies that have been dispensed.
For services performed on or after 11/01/12 – (Criterion C for high utilization) - If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

No documentation was received in response to the Additional Documentation Request letters.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code A4253. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from June 1 through August 31, 2014, resulted in an overall error rate of 80%.

Top Denial Reasons

- The requested documentation was not received by the contractor within the allotted timeframe.
- No proof of delivery was received.
- The order submitted was invalid.
- The refill requirements were not met.

Going Forward

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

Educational Resources

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

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

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

Policy Education

The requested documentation was not received by the contractor within the allotted timeframe.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

No proof of delivery was received.
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

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

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

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

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

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

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

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

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

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

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

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

The order submitted was invalid.
The Program Integrity Manual (PIM) 5.2.2 states that equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders). Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4. The dispensing order must be available upon request. For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

The Program Integrity Manual (PIM) 5.2.3 states that a detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

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

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

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

For the "date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders). Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable (PIM 5.9). The detailed description in the written order may be either a narrative description or a brand name/model number. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4. The DWO must be available upon request.

The refill requirements were not met.
For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products (A4233–A4236, A4253, A4256, A4258 and A4259) that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6).

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

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three (3)-month quantity at a time.

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

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

The E0260 review involved 1700 claims, of which 1451 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 86%.

Top Denial Reasons

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

Going Forward

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

Educational Resources

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

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

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

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

Policy Education

The medical documentation submitted did not support the criteria for a semi-electric bed.
A semi-electric hospital bed is covered if the patient meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

The medical documentation submitted did not support the criteria for a fixed height bed.
A fixed height hospital bed is covered if one or more of the following criteria (1-4) are met:

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

There was no documentation submitted.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

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

The written order prior to delivery (WOPD) submitted contained an invalid date stamp or equivalent.
A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the DMEPOS supplier's possession BEFORE the item is delivered. The WOPD must include all of the items below:

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

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

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

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

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

The E0260 review involved 1,826 claims, of which 1,579 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **86%**.

Top Denial Reasons

- The medical documentation submitted did not support the criteria for a semi-electric bed.
- The medical documentation submitted did not support the criteria for a fixed height bed.
- No documentation was provided in response to the additional documentation request (ADR).
- The proof of delivery (POD) submitted was invalid.

Going Forward

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

Educational Resources

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

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

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

Policy Education

The medical documentation submitted did not support the criteria for a semi-electric bed.
A semi-electric hospital bed is covered if the patient meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

The medical documentation submitted did not support the criteria for a fixed height bed.
A fixed height hospital bed is covered if one or more of the following criteria (1-4) are met:

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

No documentation was provided in response to the ADR.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

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

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

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

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

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

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

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

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the item is delivered directly by the supplier, the date the beneficiary received the DMEPOS item must be the date of service on the claim.

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

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

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

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

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

ICD-10 Compliance Date Is October 1, 2015 – Reminder

The U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015, as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

The rule requires the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

For resources on transitioning to ICD-10, visit the ICD-10 website.

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 September 26, 2014

ICD-10 Updates to LCDs and Policy Articles – Updated

Originally Published April 10, 2014
Updated September 25, 2014

As promised in our March 20, 2014, publication, all Local Coverage Determinations (LCDs) and related Policy Articles (PAs) have been updated and are included in the Medicare Coverage Database. To keep separate the ICD-9s from the ICD-10s, all ICD-10 LCDs and PAs (with and without diagnosis codes) have been assigned new ID numbers.

The Centers for Medicare & Medicaid Services (CMS) has determined that although new LCD numbers are assigned, the policies shall not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD.

For more information, CMS has dedicated a page to ICD-10 at http://www.cms.gov/Medicare/Coding/ICD10/index.html. This page is updated regularly, usually at least once per week, and houses resources, articles and products concerning ICD-10. Suppliers can check the latest news specific to ICD-10 as well as reference applicable Medicare Learning Network (MLN) publications.

The following list of LCDs and related PAs contains diagnoses that have been updated to ICD-10 codes:

L33686 Ankle-Foot/Knee-Ankle-Foot Orthosis

L33690 Automatic External Defibrillators

L33317 External Breast Prostheses

L33794 External Infusion Pumps

L33822 Glucose Monitors

L33785 High Frequency Chest Wall Oscillation Devices

A25474 Immunosuppressive Drugs – Policy Article

A52509 Intravenous Immune Globulin – Policy Article

L33318 Knee Orthoses

L33795 Mechanical In-exsufflation Devices

L33370 Nebulizers

A52479 Oral Anticancer Drugs – Policy Article

A52480 Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) – Policy Article

L33611 Oral Appliances for Obstructive Sleep Apnea

L33641 Orthopedic Footwear

L33796 Osteogenesis Stimulators

L33828 Ostomy Supplies – Policy Article

L33797 Oxygen and Oxygen Equipment

L33718 Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

L33642 Pressure Reducing Support Surfaces – Group 2

L33692 Pressure Reducing Support Surfaces – Group 3

L33793 Refractive Lenses

L33612 Suction Pumps

L33369 Therapeutic Shoes for Persons with Diabetes – Policy Article

L33832 Tracheostomy Care Supplies – Policy Article

L33802 Transcutaneous Electrical Nerve Stimulators (TENS)

L33803 Urological Supplies

L34824 Vacuum Erection Devices (VED)

L33312 Wheelchair Seating

LCD AND POLICY ARTICLE REVISIONS

LCD and Policy Article Revision Summary

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

Date	Policy	Revision
October 9, 2014	Respiratory Assist Devices	**LCD** Revision Effective Date: 12/01/2014 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Definitions of Central Sleep Apnea and Complex Sleep Apnea to include a CAHI index and expands signs and symptoms that describe the conditions Revised: Severe COPD to clarify that definitive testing is not necessary to exclude OSA when the clinical picture is sufficient Revised: Severe COPD to clarify that nocturnal oximetry is a cumulative 5 minutes of testing Revised: Hypoventilation Syndromes to remove FEV1 Revised: PSG testing to also include HST testing when used in the in-patient hospital setting to establish or rule out the diagnosis of OSA Added: Ventilator section based upon NCD and April 2014 coding and coverage article Added: Sleep Test coverage and payment rules **Policy Article** Revision Effective Date: 12/01/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: ACA 6407 prescriber requirements

LCD AND POLICY ARTICLE REVISIONS

October 2, 2014	External Infusion Pumps	**LCD** Revision Effective Date: 11/01/2014 DOCUMENTATION REQUIREMENTS: Removed: Suggested form for inotrope information
October 2, 2014	Knee Orthoses	**LCD** Revision Effective Date: 10/01/2014 COVERAGE INDICATIONS, LIMITATIONS, and/or MEDICAL NECESSITY: Added: Codes K0901 and K0902 to Prefabricated Knee Orthoses section Added: Base Codes K0901 and K0902 to Addition Codes tables Added: Codes K0901 and K0902 to the requirement (1) for custom fabricated knee orthosis with an adjustable flexion and extension joint HCPCS CODES: Added: Codes K0901 and K0902 ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: Added: Codes K0901 and K0902 to Group 4 Codes **Policy Article** Revision Effective Date: 10/01/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Codes K0901 and K0902 to Correct coding of prefabricated knee orthoses Added: Reasonable Useful Lifetime for codes K0901 and K0902 CODING GUIDELINES: Added: Codes K0901 and K0902 to coding guidelines Added: Base Codes K0901 and K0902 to Addition Codes table
October 2, 2014	Therapeutic Shoes for Persons with Diabetes	**Policy Article** Revision Effective Date: 11/01/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Criterion 5 (in-person fitting requirement)

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.

MEDICARE SECONDARY PAYER

MSP Group Health Plan Working Aged Policy – Define "Spouse;" Same-Sex Marriages

MLN Matters® Number: MM8875
Related Change Request (CR) #: CR 8875
Related CR Release Date: October 10, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R106MSP
Implementation Date: January 1, 2015

Provider Types Affected

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

Provider Action Needed

Section 3 of the Defense of Marriage Act (DOMA) provided for purposes of federal law, the term "spouse" could not include individuals in a same-sex marriage. Because the Medicare Secondary Payer (MSP) Working Aged provisions only apply to subscribers and their spouses, the Working Aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage.

The United States Supreme Court has invalidated this DOMA provision. Thus, the Centers for Medicare & Medicaid Services (CMS) is no longer prohibited from applying the MSP Working Aged provision to individuals in a same-sex marriage.

Effective January 1, 2015, the rules below apply with respect to the term "spouse" under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages.

- If an individual is entitled to Medicare as a spouse based upon the Social Security Administration's rules, that individual is a "spouse" for purposes of the MSP Working Aged provisions.
- If a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory, or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are "spouses" for purposes of the MSP Working Aged provisions.
- Where an employer, insurer, third party administrator, Group Health Plan (GHP), or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in question. If such an individual is reported as a "spouse" through the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

Make sure your billing staffs are aware of these changes.

Background

Based on Change Request (CR) 8875, effective January 1, 2015, the definition of a spouse for purposes of the working aged provisions means "a person who is entitled to Medicare as a spouse based upon the Social Security Administration's rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction."

The expanded rules for the definition of "spouse," including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

To the extent an employer, insurer, third party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader definition of "spouse" for MSP purposes prior to January 1, 2015, it may do so. However, MACs may not apply the revised definition for Medicare purposes for coverage dates prior to January 1, 2015. Nor may MACs accept a definition of spouse broader than that quoted above. In the event, Medicare does pay for coverage prior to January 1, 2015, it will pursue recovery, as applicable.

Additional Information

The official instruction, CR8875, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106MSP.pdf on the CMS website.

Submitting Medicare Secondary Payer Claims

Review these reminders for successfully submitting a claim when Medicare is the secondary payer.

- Collect full beneficiary health insurance information at each visit.
- Identify the primary payer prior to submission of a claim and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if treatment is rendered to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to

Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.

A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Collect Full Beneficiary Health Insurance Information
It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their beneficiary or beneficiary's representative questions concerning the MSP (Medicare as Secondary Payer) status. The model hospital admissions questionnaire, published by CMS, may be used as a guide to collect this information from beneficiaries. This tool is available on the CMS website in the "MSP Manual" in Chapter 3, Section 20.2.1. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

Identify and Bill Correct Primary Payer
Medicare regulations require that all entitles that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary or secondary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a beneficiary is seen for multiple services, each service should be billed to the appropriate primary payer prior to billing Medicare.

Accident Related Claims
If the beneficiary has an open MSP Liability (L), No-Fault (NF), or Workers' Compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. DO NOT deny treatment.

To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that all necessary MSP payment information is included, as found on the primary payer's remittance advice (e.g., claim adjustment reason code for specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process the claim accordingly.
2. If the beneficiary has both a Group Health Plan (GHP) MSP coverage and L, NF, or WC coverage, suppliers are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once the GHP remittance advice is received, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with the claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny the claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, the claim must be submitted to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If a claim was inappropriately denied by Medicare:

- Ensure that the correctly completed claim has been submitted to the appropriate payer(s).
- Contact the Medicare contractor if there is reason to believe a claim was denied inappropriately.
- Information may need to be provided to the Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the Benefits Coordination and Recovery Center (BCRC) at 1-855-798-2627 if an MSP record needs to be updated.

- The BCRC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers should report directly to the BCRC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury Federal program coverage changes, or any other insurance coverage information.

- Providers, physicians, or other suppliers may request an update to an MSP record if there is appropriate documentation to substantiate the change. The documentation may need to be faxed to the BCRC at 1-405-869-3307 or the beneficiary may need to be on the call to validate the change.
- Do not call the BCRC to adjust claims or inquire about mistaken payments.

Additional Information

Specific claim-based issues or questions (including claim processing) should be addressed to Noridian Medicare Jurisdiction D by calling 1-877-320-0390.

If new beneficiary coverage that may be primary needs to be reported to Medicare or for questions regarding MSP status or claims investigation activities, contact the BCRC.

The Medicare Learning Network (MLN) has a Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff (ICN 006903) at http://www.cms.gov/outreach-and-education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf. This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the BCRC.

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

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

The K0001 review involved 702 claims, of which 633 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 83%.

The K0003 review involved 409 claims, of which 394 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 95%.

The K0004 review involved 168 claims, of which 163 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 93%.

Top Denial Reasons

- A home assessment to determine that the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided was not submitted or was invalid.
- The documentation submitted did not support that the beneficiary'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 requires a lightweight wheelchair (K0003).
- The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).
- There was no documentation submitted.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Manual Wheelchair Bases Local Coverage Determination (LCD) and Policy Article.

Suppliers can also review a specific policy Documentation Checklist for Manual Wheelchairs on the Noridian website.

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

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

Policy Education

A home assessment to determine that the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided was not submitted or was invalid.
Documentation must support that the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

Information about whether the beneficiary's home can accommodate the wheelchair (Criterion C), also called the home assessment, must be fully documented in the medical record or elsewhere by the supplier. For manual wheelchairs, the home assessment may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery, verify that the item delivered meets the requirements specified in criterion C. Issues such as the physical layout of the home, surfaces to be traversed, and obstacles must be addressed by and documented in the home assessment. Information from the beneficiary's medical record and the supplier's records must be available upon request.

The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker (Criterion B).

The documentation submitted did not support that the beneficiary requires a lightweight wheelchair (K0003).
A lightweight wheelchair (K0003) is covered when the documentation supports that the beneficiary meets both criteria (1) and (2):

1. Cannot self-propel in a standard wheelchair in the home; and
2. The beneficiary can and does self-propel in a lightweight wheelchair

The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).
A high strength lightweight wheelchair (K0004) is covered when the documentation supports that the beneficiary meets criteria (1) or (2):

- The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; or
- The beneficiary requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

There was no documentation submitted.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

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

PMD Prior Authorization Requests Top Reasons for Non-Affirmation

The Jurisdiction D DME MAC Medical Review department provides suppliers the opportunity to request prior authorization for select power mobility devices (PMDs) per the PMD demonstration guidelines. The top reasons for non-affirmation from June 2014 through August 2014 are indicated below.

Top Reasons for Non-Affirmed Decisions

- The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home.
- When a power wheelchair is requested, the face-to-face examination documentation does not indicate that the use of a power operated vehicle (POV) has been excluded.
- The face-to-face examination does not indicate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- The face -to-face examination does not indicate the beneficiary is able to safely transfer to and from the power mobility device.
- The face -to-face examination does not indicate the beneficiary is able to operate the tiller steering system of the power mobility device.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127.

Suppliers can also review resources for the Prior Authorization Demonstration on the Noridian website. There you will find information related to Prior Authorization Request (PAR) Demonstration including how to submit PARs, documentation and educational resources, CMS Resources, and the HCPCS codes that are eligible for the PAR demonstration.

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

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

Policy Education

The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs).
The beneficiary's medical documentation does not support criterion C per Local Coverage Determination (LCD) L23598.

- The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.
  - Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
  - An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

When a POV is requested, the face-to-face examination does not indicate that the use of a POV has been excluded.
The beneficiary's medical documentation does not support criterion D per LCD L23598.

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

- The beneficiary is able to:
  - Safely transfer to and from a POV, and

- Operate the tiller steering system, and
- Maintain postural stability and position while operating the POV in the home.

The face-to-face examination does not indicate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
The beneficiary's medical documentation does not support criterion B per Local Coverage Determination (LCD) L23598.

- The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker

When a POV is requested, the face -to-face examination does not indicate the beneficiary is able to safely transfer to and from the power mobility device.
The beneficiary's medical documentation does not support criterion D per LCD L23598.

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

- The beneficiary is able to:
  - Safely transfer to and from a POV, and
  - Operate the tiller steering system, and
  - Maintain postural stability and position while operating the POV in the home.

When a POV is requested, the face -to-face examination does not indicate the beneficiary is able to operate the tiller steering system of the power mobility device.
The beneficiary's medical documentation does not support criterion D per LCD L23598.

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

- The beneficiary is able to:
  - Safely transfer to and from a POV, and
  - Operate the tiller steering system, and
  - Maintain postural stability and position while operating the POV in the home.

Power Mobility Devices and All Related Accessories (HCPCS K0823) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code K0823 and all related accessories. The quarterly edit effectiveness results from April 2014 through July 2014 are as follows:

The K0823 review involved 175 claims, of which 96 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 57%.

Top Denial Reasons

- The documentation submitted does not support the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.
- The face-to-face examination submitted was incomplete or missing elements.
- **The documentation submitted contained no detailed product description or the detailed product description submitted was invalid.**
- There was no documentation submitted.
- The 7-element order submitted was incomplete or missing elements.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Power Mobility Devices (PMD) Local Coverage Determination (LCD) and Policy Article.

Suppliers can also review a specific policy Documentation Checklist for Power Mobility Devices on the Noridian website.

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

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

Policy Education

The beneficiary's medical records do not support that the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.
The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform mobility related activities of daily living (MRADL) during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

The face-to-face examination submitted was incomplete or missing elements.
For a power operated vehicle (POV) or power wheelchair (PWC) to be covered, the treating physician must conduct a face-to-face examination of the beneficiary before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device.

The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

- History of the present condition(s) and past medical history that is relevant to mobility needs
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the beneficiary can walk without stopping
  - Pace of ambulation
  - What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
  - What has changed to now require use of a power mobility device
  - Ability to stand up from a seated position without assistance
  - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion

- Neurological examination
  - Gait
  - Balance and coordination

The evaluation should be tailored to the individual beneficiary's conditions. The history should paint a picture of the beneficiary's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability.

Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier.

A date stamp or equivalent must be used to document the date that the supplier receives the report of the face-to-face examination. The written report of this examination must be available upon request.

The documentation submitted contained no detailed product description or the detailed product description submitted was invalid.
Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description).

This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the PWC or POV. A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request.

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

There was no documentation submitted.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

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

The 7-element order submitted was incomplete or missing elements.
The order, referred to as the 7-element order that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article) must contain all of the following elements:

- Beneficiary's name
- Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific.
- Date of the face-to-face examination
- Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
- Length of need
- Physician's signature
- Date of physician signature

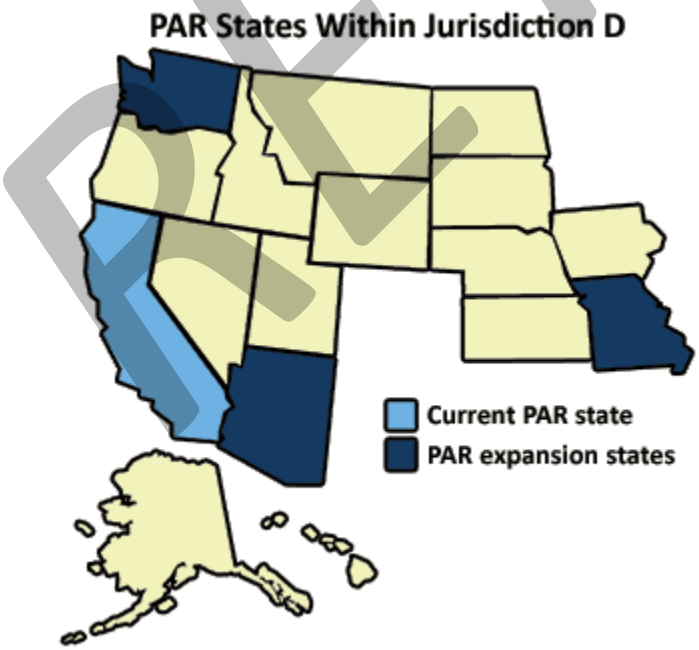
The Supplier may provide a template order listing the seven required elements but is prohibited from completing any part of it. The treating physician completing the face-to-face requirements must write the 7-element order. The 7-element order may only be written after the completion of the face-to-face exam requirements. Refer to the Policy Article Non-Medical Necessity Coverage and Payment Rules section for information regarding the statutory requirements for PMDs.

A date stamp or equivalent must be used to document receipt date. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added section 1834(a)(1)(E)(iv) which provides that payment may not be made for a motorized or power wheelchair unless the practitioner who has conducted the face-to-face examination him or herself writes the 7-element order. It is a statutory requirement that all items of the 7-element order be entered specifically by and only by the practitioner who has conducted the face-to-face requirements.

For a POV or power wheelchair to be covered, the supplier must receive from the treating physician a written order, termed the 7-element order, containing all the elements specified in the Documentation Requirements section of the Local Coverage Determination within 45 days after completion of the physician's face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 45 days after discharge.) If these requirements are not met, the claim will be denied as non-covered.

Prior Authorization Coming to Arizona, Missouri and Washington October 1, 2014

Expansion of the power mobility device (PMD) prior authorization request (PAR) demonstration is scheduled for expanding to Arizona, Missouri and Washington for applicable PMD 7-element orders written on or after October 1, 2014.



Noridian Healthcare Solutions (Noridian) would like to provide helpful information regarding the prior authorization request (PAR) demonstration process, common reasons for non-affirmation of requests, and the locations and links to educational resources that can be found on the Jurisdiction D website.

With expansion, the PAR demonstration will apply to beneficiaries residing in the following 19 states (shown with the corresponding Durable Medical equipment Medicare Administrative Contractors (DME MACs):

For Jurisdiction D (Noridian) the demonstration will include the states of California, Missouri, Arizona, and Washington.

Jurisdiction A (NHIC) will include the states of New York, Pennsylvania, Maryland, and New Jersey in the demonstration.

Jurisdiction B (National Government Services) will expand to include Illinois, Indiana, Ohio, Kentucky, and Michigan.

For Jurisdiction C (CGS) the demonstration will include the states of North Carolina, Florida, Texas, Louisiana, Tennessee, and Georgia.

Use the following links to read more about prior authorization:

- Documentation to include in a PAR package submission
- What is a face to Face (F2F) date?
- Guidelines for expedited requests
- Using the PAR submission cover sheet
- Common reasons for rejection
- Affirmative and Non-affirmative Decisions
- Reasons for non-affirmation and helpful references
- Remember the Unique Tracking Number (UTN)
- Still have questions?
- Get registered for Endeavor today!
- Educational Resources on the Noridian Medicare Website

Documentation to Include in PAR Package Submission

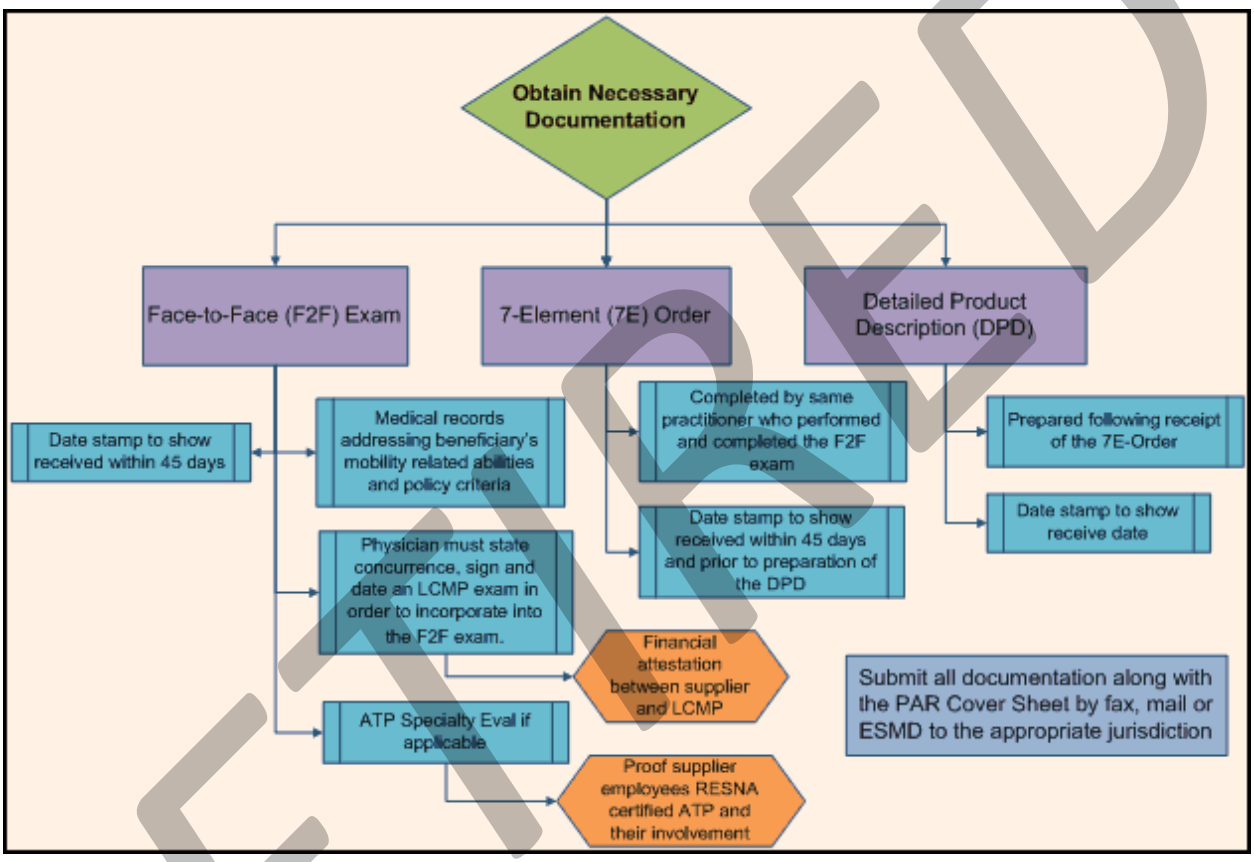
Documentation should include the following:

- Face to Face (F2F) Exam
  - Date stamp to show product was received within 45 days
  - Medical records addressing the beneficiary's mobility related abilities and policy criteria
  - Physician signed licensed clinical medical professional (LCMP) exam stating concurrence in order to incorporate it into the F2F exam
    - Financial attestation between supplier and LCMP
  - Assistive Technology Professional (ATP) Specialty Evaluation if applicable
    - Proof the supplier employees are Rehabilitation Engineering & Assistive Technology Society of North America (RESNA) certified ATP and their involvement
- 7-Element (7E) Order
  - Completed by the same practitioner who performed and completed the F2F exam
  - Date stamp to show the product was received within 45 days and prior to preparation of the Detailed Product Description (DPD)

- Detailed Product Description
  - Prepared following receipt of the 7E order
  - Date stamp to show the received date

Submit all documentation along with a PAR cover sheet by fax, mail, or esMD to the appropriate jurisdiction.

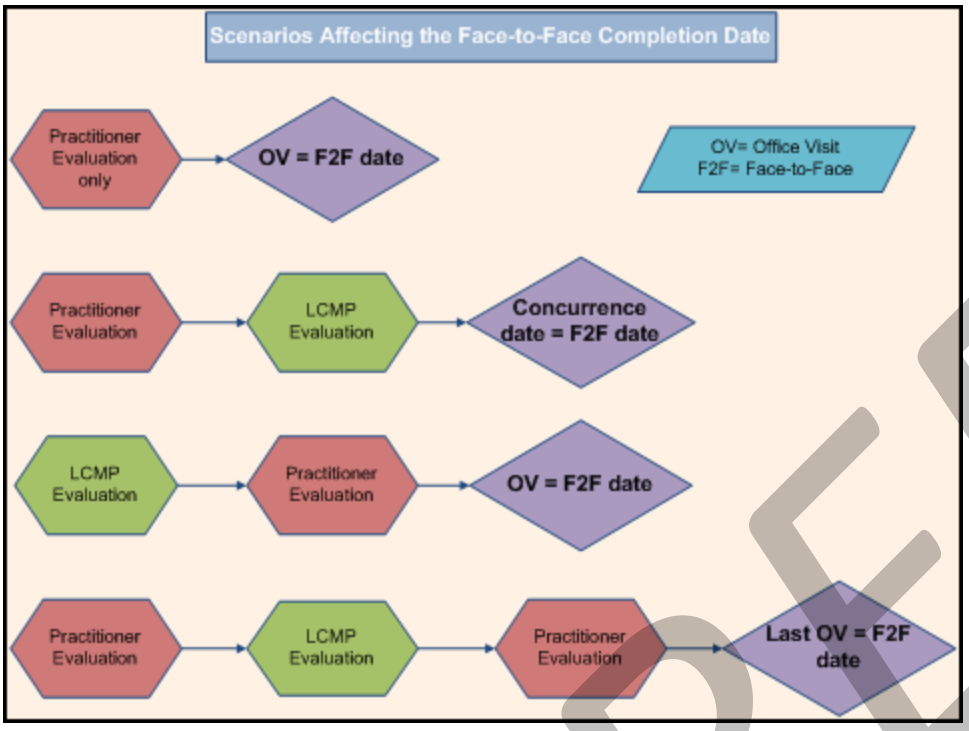
The chart below summarizes the order of events and the necessary documentation that is needed when submitting a PAR package. Assuring all components are completed and included within the submission will help the efficiency of the processing and decision making process.



What is a F2F date?

Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios provides scenarios for properly dating the F2F examination on the 7E order. The information and flow chart below demonstrate the different scenarios that may be encountered:

- If there is a practitioner evaluation only, the date of the office visit with the practitioner must be used as the F2F date.
- If there is a practitioner evaluation followed by a LCMP evaluation, the date of the practitioner's concurrence must be used as the F2F date.
- If there is a LCMP evaluation followed by a practitioner evaluation, the practitioner evaluation date must be used as the F2F date.
- If there is a practitioner evaluation followed by a LCMP evaluation a subsequent practitioner evaluation, the last office visit with the practitioner must be used as the F2F date.



Guidelines for Expedited Requests
In very rare emergent circumstances a 48-hour expedited review may be requested. In order to be processed as an expedited request, circumstances must be in accordance with the following guidelines:

- The expedited request must be accompanied by supporting medical documentation
- The physician indicates clearly, with supporting rationale, that the 10 business day timeframe for an initial decision could jeopardize the beneficiary's life or health

Expedited requests will be downgraded to standard requests when documentation does not support the above guidelines.

Using PAR Submission Cover Sheet
Completing all elements found on the submission cover sheet *correctly* and *completely* aids in the efficient processing of each PAR: Cover Sheet [PDF].

Common Reasons for Rejection
There are various reasons that a PAR may be rejected and not reviewed. Proper completion of the cover sheet, ensuring a complete package is submitted each time, and a thorough intake process aids in minimizing the risk of rejections. The most common reasons for rejection include:

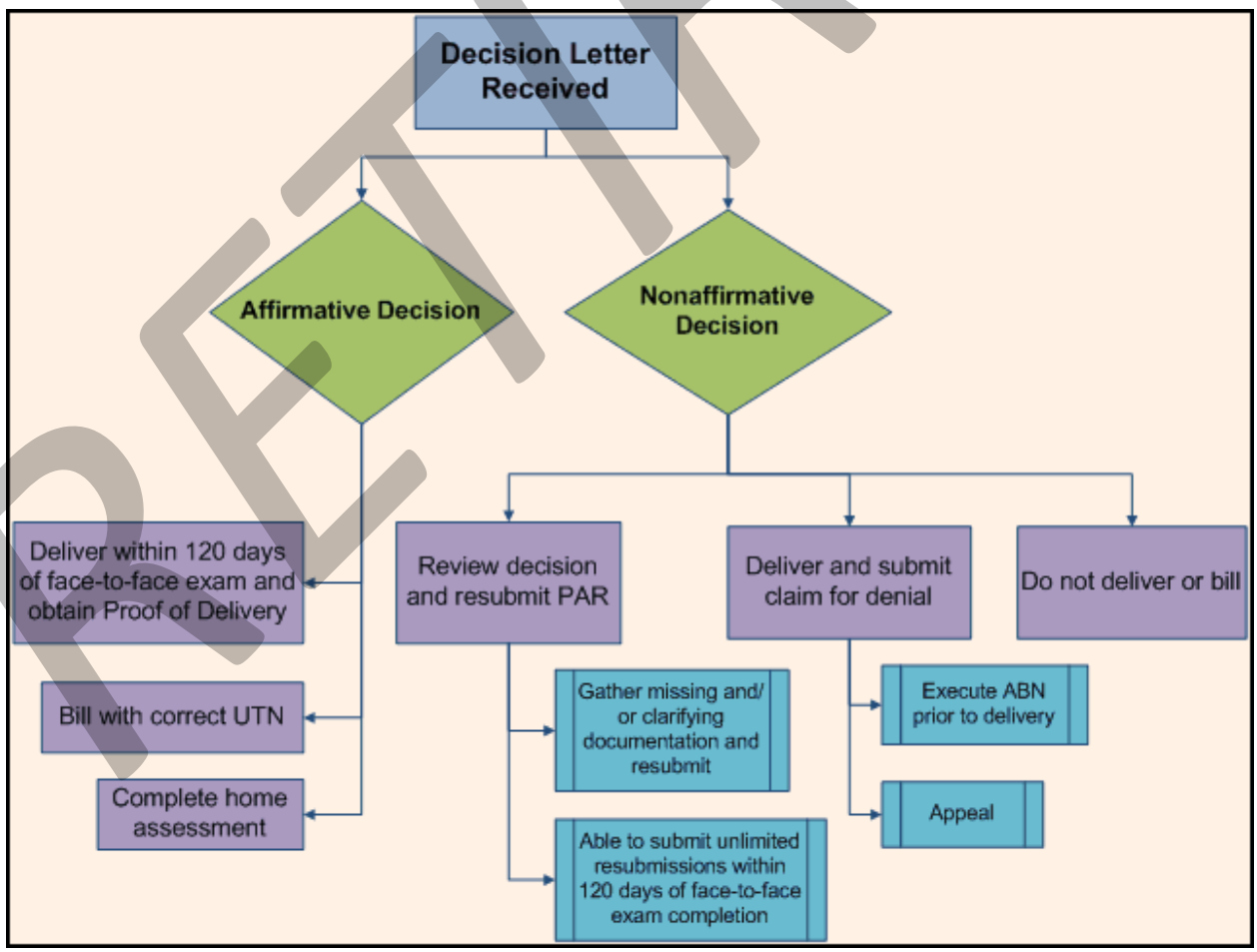
- The base PMD code is not specified
- The base PMD code is not subject to the PAR demonstration
- The beneficiary has a Representative Payee on file and is not subject to the demonstration
- The beneficiary does not reside in a demonstration state within Jurisdiction D
- The beneficiary is deceased
- The 7E order is dated prior to the PAR implementation date for the state
- The PAR is a duplicate submission
- The subsequent PAR does not contain a complete package consisting of all newly acquired and all previously submitted documentation

Affirmative and Non-affirmative Decisions
After the PAR submission goes through the medical review process a decision letter is mailed to the supplier, beneficiary and physician.

An affirmative decision means that based on the review, it was determined the beneficiary meets the medical necessity requirements established by Medicare for the PMD base requested. This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare Secondary Payer, etc.) have been met. Only upon submission of a complete claim can the DME contractor make a full and complete determination.

A non-affirmative decision requires follow-up by the supplier prior to submitting a subsequent submission. The following information and chart provides direction on the process following a PAR decision.

- Affirmative Decision
  - Complete a home assessment
  - Deliver PMD within 120 days of F2F exam and obtain Proof of Delivery
  - Bill with the correct Unique Tracking Number (UTN)
- Non-affirmative Decision
  - Review decision and submit a subsequent PAR
    - Gather missing and/or clarifying documentation and resubmit
    - Able to submit unlimited resubmissions within 120 days of F2F exam completion
  - Deliver PMD and submit claim for denial
    - Execute Advance Beneficiary Notice of non-coverage (ABN) prior to delivery
    - File an appeal
  - Do not deliver or bill



Reasons for Non-Affirmation and Helpful References

- A medical record or an order is improperly amended
  - Changing a 7 element order for a power mobility device
  - Medicare Program Integrity Manual
  - PMD Demonstration Operational Guide
- The F2F examination date listed on the 7E order is incorrect
  - Face to face examination date on 7 – element order for power mobility devices
- The evidence of RESNA certification and/or ATP involvement is missing
  - ATP RESNA Certification Requirement Reminder
- A statement indicating the supplier has no financial relationship with the LCMP involved in the evaluation is missing
  - Attestation Statements Must Accompany Advance Determination of Medicare Coverage (ADMC), PAR and PMD Claims for Medical Review
- The CMS requirements for signatures are not met
  - Complying with Medicare signature requirements
  - MLN Matters 6698 Revised

Remember the UTN

Once an affirmed decision has been made, submit the claim, including the UTN, as follows:

The submission of the prior authorized PMD claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim, the UTN is submitted in Item 23 of the 1500 Claim Form. For electronic claims the UTN is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).

Still Have Questions?

Call the Supplier Contact Center or Interactive Voice Response (IVR) at: 1-877-320-0390

- IVR eligibility and general information availability: 24/7
- IVR claim/request status availability: Monday – Friday 6 a.m. to 8 p.m. CT
- Contact Center availability: Monday – Friday 8 a.m. to 6 p.m. CT

Noridian encourages suppliers who would like additional one-on-one education to fill out the Education Request Form [PDF]. Be as specific as possible when filling out the form; Protected Health Information (PHI) must not be included. This education is a way for suppliers to get a more individualized learning experience. Noridian still encourages suppliers to attend our web-based workshops and in-person seminars as key sources of training. Suppliers can also visit the Noridian Medicare Prior Authorization page for more information.

Get registered for Endeavor today!

Sign up for Endeavor, the free web-based portal which provides the capability to check eligibility, claim status, PAR status, submit redeterminations, and more. To learn more about Endeavor, click here.

Educational Resources on Noridian Medicare Website

- Training and Events page
- DME On Demand presentations – Prerecorded presentations that enable viewers to watch and listen to a presentation at their convenience.
  - DME on Demands specific to PMDs include:
    - PMD Captain's Chair vs. Sling/Solid Back Chair – 7 minutes
    - Power Operated Vehicles: Coverage Criteria – 5 minutes

  - Power Mobility Device Coverage Criteria A–C – 7 minutes
  - More to come!
- DME on Demands specific to PMD PAR are:
  - Beneficiary Address Change – 7 minutes
  - Demonstration and Expansion – 6 minutes
  - Scenarios – 6 minutes
  - Submitting a PAR – 5 minutes
- Resources
  - Local Coverage Determination L23598 and Policy Article A41127 for Power Mobility Devices
  - Documentation Checklists
  - Physician Resource Letter
  - MLN Matters SE1231 – Revised – Medicare Demonstration Allows Prior Authorization for Certain PMDs

E1825, E1830 and E1831 and Use of Modifiers

Joint DME MAC Publication

Effective for dates of service on or after January 1, 2015, devices coded with HCPCS code E1825 (Dynamic adjustable finger extension/flexion device, includes soft interface material) must use one of the following modifiers when billing this code:

FA Left hand, thumb
F1 Left hand, second digit
F2 Left hand, third digit
F3 Left hand, fourth digit
F4 Left hand, fifth digit
F5 Right hand, thumb
F6 Right hand, second digit
F7 Right hand, third digit
F8 Right hand, fourth digit
F9 Right hand, fifth digit

Effective for dates of service on or after January 1, 2015, devices coded with HCPCS Codes E1830 (Dynamic adjustable toe extension/flexion device, includes soft interface material) or E1831 (Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories) must use one of the following modifiers when billing these codes:

TA Left foot, great toe
T1 Left foot, second digit
T2 Left foot, third digit
T3 Left foot, fourth digit
T4 Left foot, fifth digit
T5 Right foot, great toe
T6 Right foot, second digit
T7 Right foot, third digit
T8 Right foot, fourth digit
T9 Right foot, fifth digit

Failure to append a modifier to claim lines with codes E1825, E1830 or E1831 will result in a rejection for incorrect coding.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code J7605 and J7626, nebulizer inhalation drugs. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from July 1 through September 30, 2014, resulted in an overall error rate of 32%.

Top Denial Reasons

- Requested documentation was not received by the contractor within the allotted timeframe.
- There were no medical records submitted to support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9)
- The proof of delivery submitted was invalid.
- The refill requirements were not met.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizer Local Coverage Determination (LCD) L11488 and Policy Article A24942.

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

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

Policy Education

Documentation not received within the correct time frame.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

There were no medical records submitted to support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9).
Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

The proof of delivery submitted was invalid.
CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 5.8

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method

of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

For the purpose of the delivery methods noted below, designee is defined as "Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

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

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

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

Method 1 – Direct Delivery to the Beneficiary by the Supplier
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

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

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

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

Method 3 – Delivery to Nursing Facility on Behalf of a Beneficiary
When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

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

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

The refill requirements were not met.
For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products (A4619, A7003-A7017, A7525, all inhalation medications) that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS' Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6).

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

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three (3)-month quantity at a time.

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

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies, i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) – the supplier should assess the quantity of each item that the beneficiary still has remaining, to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.

For non-consumable supplies, i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies) - the supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

Coverage Reminder – Negative Pressure Wound Therapy Devices Revised – October 2, 2014

Note: This is a revision to a previous version published in August 2014. It corrects an error in the "Prescriptions" requirement section that incorrectly referenced the Affordable Care Act (ACA) §6407 requirement for HCPCS code E2402. The ACA requirements do not apply to code E2402; however, code E2402 does require a written order prior to delivery.

Joint DME MAC Publication

A recent examination of Comprehensive Error Rate Testing (CERT) reviews for Negative Pressure Wound Therapy (NPWT) 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

- Prescription Related
  - Referring physician's detailed written order missing – 9.09%
- Reasonable & Necessary (R&N) Related
  - Coverage criteria A not met – 63.64%
  - Coverage criteria B not met – 9.09%
  - Coverage criteria C not met – 9.09%
- Other
  - Beneficiary was in a Part A stay on date of service (DOS) – 9.09%

Payment Rules

Prescriptions:
All items billed to Medicare require a prescription. NPWT base code E2402 (NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE) requires that the prescription must meet the Written Order Prior to Delivery requirements.

Reasonable and Necessary (R&N) Criteria:
NPWT is only covered for certain types of wounds when other treatments have failed. The LCD specifies the following:

A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion A or B is met:

A. Ulcers and Wounds in the Home Setting:

The beneficiary has a chronic Stage III or IV pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT.

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
   a. Documentation in the beneficiary's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
   b. Application of dressings to maintain a moist wound environment, and
   c. Debridement of necrotic tissue if present, and.
   d. Evaluation of and provision for adequate nutritional status

2. For Stage III or IV pressure ulcers:
    a. The beneficiary has been appropriately turned and positioned, and
    b. The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see LCD on support surfaces), and
    c. The beneficiary's moisture and incontinence have been appropriately managed
3. For neuropathic (for example, diabetic) ulcers:
    a. The beneficiary has been on a comprehensive diabetic management program, and
    b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities
4. For venous insufficiency ulcers:
    a. Compression bandages and/or garments have been consistently applied, and
    b. Leg elevation and ambulation have been encouraged

B. Ulcers and Wounds Encountered in an Inpatient Setting:

1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
2. The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).

Coverage of NPWT ends when certain conditions occur. The LCD specifies:

C. For wounds and ulcers described under A or B above, once placed on an NPWT pump and supplies, in order for coverage to continue, a licensed medical professional must do the following:

1. On a regular basis,
    a. Directly assess the wound(s) being treated with the NPWT pump, and
    b. Supervise or directly perform the NPWT dressing changes, and
2. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

Documentation:
In the event of a claim review,

- Medicare requires that there is a prescription (order) for every separately billable item.
- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements are met.

Durable Medical Equipment Provided During a Part A Stay:
Durable Medical Equipment (DME) is only covered when provided for use in the beneficiary's home. DME provided during a covered Part A stay is not eligible for separate reimbursement by the DME MACs.

This article presents a summary of the policy requirements related to the errors identified in the CERT reviews. There are additional requirements necessary for coverage that are not discussed. Refer to the LCD and related Policy article for complete information. Further education regarding this policy is available on your DME MAC contractor website.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L1960. The quarterly edit effectiveness results from June 2014 through September 2014 are as follows:

The L1960 review involved 213 claims, of which 170 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 81%.

The L1970 review involved 335 claims, of which 284 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 83%.

The L4360 review involved 1,262 claims, of which 1,237 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 98%.

Top Denial Reasons

- The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis
- Documentation submitted was insufficient to support custom coverage criteria
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation submitted was insufficient to support basic coverage criteria
- Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed
- No proof of delivery submitted

Going Forward

Based on the results of these reviews, Noridian will continue with the Prepayment Service Specific Reviews.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Ankle-Foot/Knee-Ankle-Foot Orthosis (AFO) Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review a specific policy Documentation Checklist for Ankle-Foot/Knee-Ankle-Foot Orthosis on the Noridian website.

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

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

Policy Education

The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis.
For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support medical necessity of custom-fabricated rather than a prefabricated orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

Documentation submitted was insufficient to support custom coverage criteria.
AFOs and KAFOs that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

- The beneficiary could not be fit with a prefabricated AFO or,
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than six months) or,

- There is a need to control the knee, ankle or foot in more than one plane or,
- The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury or,
- The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions.

If a custom-fabricated orthosis is provided but basic coverage criteria and the additional criteria 1-5 for a custom-fabricated orthosis are not met, the custom-fabricated orthosis will be denied as not reasonable and necessary.

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. The supplier standards can be found in 424 CFR Section 424.57(c).

Documentation submitted was insufficient to support basic coverage criteria.
AFOs described by codes L1900, L1902–L1990, L2106–L2116, L4350, L4360, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.
Items requiring substantial modification by a qualified practitioner (as defined in the related Policy Article Coding Guidelines) are coded as custom fitted (L1910, L1930, L1932, L1951, L1971, L2035, L2112-L2116, L2132-L2136, L4360, L4386, L4396). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Custom fitted orthotics are:

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from Off –the-Shelf (OTS) to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

No proof of delivery submitted.
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5980. The quarterly edit effectiveness results from May 2014 through August 2014 are as follows:

> The L5980 review involved 48 claims, of which 40 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **83%**.

Top Denial Reasons

- Documentation does not support the functional level billed on the claim.
- Medical record documentation does not support medical need for replacement.
- Medical record documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time.
- Medical record documentation does not support the beneficiary is motivated to ambulate.
- The documentation submitted was not properly authenticated.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

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

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

Policy Education

Documentation does not support the functional level billed on the claim.
A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to: 1. The beneficiary's past history (including prior prosthetic use if applicable); and 2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and 3. The beneficiary's desire to ambulate.

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

Medical record documentation does not support medical need for replacement.
Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following: 1. A change in the physiological condition of the beneficiary; or 2. Irreparable wear of the device or a part of the device; or 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Medical record documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time and the medical record documentation did not support the beneficiary is motivated to ambulate.

A lower limb prosthesis is covered when the beneficiary:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate

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

The documentation submitted was not properly authenticated.
Per PIM 3.3.2.4 – Signature Requirements: For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

Other regulations and the CMS' instructions regarding conditions of payment related to signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, National Coverage Determination (NCD), LCD and CMS manuals are silent on whether the signature needs to be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN, etc.) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, Zone Program Integrity Contractors (ZPICs) and Comprehensive Error Rate Testing (CERT) shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5981. The quarterly edit effectiveness results from June 2014 through September 2014 are as follows:

The L5981 review involved 31 claims, of which 28 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 87%.

The L5987 review involved 50 claims, of which 45 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 85%.

Top Denial Reasons

- Documentation does not support the functional level billed on the claim
- Documentation does not support medical need for replacement item(s)
- Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time

- Documentation does not support the beneficiary is motivated to ambulate
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation does not support medical necessity for the item(s) requested
- Signature requirements not met

Going Forward

Based on the results of these reviews, Noridian will continue with the Prepayment Service Specific Reviews.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses (LLP) Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

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

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

Policy Education

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

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

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

Documentation does not support medical need for replacement item(s).
Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following:

- A change in the physiological condition of the beneficiary; or
- Irreparable wear of the device or a part of the device; or
- The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate.
Lower limb prosthesis is covered when the beneficiary:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and Certificates of Medical Necessity (CMNs). The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records

from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Documentation does not support medical necessity for the item(s) requested.
For any item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

For the items addressed in the LLP LCD, the criteria for "reasonable and necessary", based on Social Security Act § 1862(a) (1) (A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Signature requirements not met.
For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

Revision Correct Coding – Palatal Lift Prosthesis

Joint DME MAC Publication

A palatal lift prosthesis is a dental appliance that is used to support the soft palate in individuals lacking the normal muscle function necessary to maintain the soft palate in its normal position.

Claims are occasionally submitted to the DME MACs using Not Otherwise Classified (NOC) HCPCS codes. When a specific code exists for any item, use of a NOC code is incorrect coding. The specific codes to be used on claims for a palatal prosthesis are:

D5955 – Palatal lift prosthesis, definitive
D5958 – Palatal lift prosthesis, interim
D5959 – Palatal lift prosthesis, modification

Current Dental Terminology (CDT) D codes are not within DME MAC jurisdiction. Claims for D codes must be submitted to the local carrier and should not be submitted to the DME MACs.

Claims for palatal lift prostheses must not be submitted to the DME MAC using HCPCS NOC (Not Otherwise Classified) codes.

Spinal Orthoses: LSO (HCPCS L0631 & L0637) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes L0631 & L0637. The quarterly edit effectiveness results from June 2014 through September 2014 are as follows:

The L0631 review involved 637 claims, of which 623 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 98%.

The L0637 review involved 515 claims, of which 506 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 98%.

Top Denial Reasons

- Documentation was insufficient to support that substantial modifications were made for the custom fitted item billed
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation was insufficient to support criteria 1
- Invalid proof of delivery
- No proof of delivery (POD)

Going Forward

Based on the results of these reviews, Noridian will continue with the Prepayment Service Specific Reviews.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses: Thoracic Lumbar Sacral Orthoses (TLSO) and Lumbar Sacral Orthoses (LSO) Local Coverage Determination (LCD) L11459 and Policy Article A23846.

Suppliers can also review a specific policy Documentation Checklist for Spinal Orthoses on the Noridian website.

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

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

Policy Education

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.

Items requiring substantial modification by a qualified practitioner are coded as custom fitted (L0454, L0456, L0458, L0460, L0462, L0464, L0466, L0468, L0470, L0472, L0488, L0490, L0491, L0492, L0626, L0627, L0630, L0631, L0633, L0635, L0637 and L0639). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.

Custom fitted orthotics are:

- Devices that are prefabricated
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.

- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Documentation was insufficient to support criteria 1.
Lumbar Sacral Orthoses (LSO) and Thoracic Lumbar Sacral Orthoses (TLSO) are covered under the Braces benefit category (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. Items that do not meet the definition of a brace are noncovered.

In order for a beneficiary's orthosis to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.

A spinal orthosis (L0450 - L0651) is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

Invalid proof of delivery/No proof of delivery.
POD is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

The proof of delivery must include:

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

- Date delivered
- Beneficiary (or designee) signature and date of signature
- Evidence of delivery (If utilizing a shipping service or mail order.)

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

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

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

PNEUMATIC COMPRESSION DEVICES

LCD and Policy Article Summary for September 11, 2014 – Draft Released to Final

Draft Pneumatic Compression Devices (PCD) Local Coverage Determination and Policy Article have been finalized.

The medical policy will be effective for claims with dates of service on or after November 1, 2014. The notice period start date is September 11, 2014 and the notice period end date is October 31, 2014.

Please review the entire LCD and related Policy Article for coverage, coding, and documentation requirements. Also review the Response to Comments Summary attached to the LCD.

Pneumatic Compression Devices LCD – Implementation Delayed

Joint DME MAC Article

The Pneumatic Compression Devices Local Coverage Determination (LCD) and related Policy Article (PA) scheduled to take effect for dates of service on or after November 1, 2014, are being delayed. Additional clinical information published since the release of the draft policy is being reviewed. No future effective date for the draft policy is available at this time. The current LCD and related PA will remain in effect.

Pneumatic Compression Devices – Response to Comments Summary

Preamble
When the DME Contractor Medical Directors published the Proposed LCD for Pneumatic Compression Devices (PCDs) in 2011, there had been a period of several years when we had regularly received requests for coverage of PCDs for peripheral arterial disease from a number of those treating these conditions, indicating the technology and its acceptance had significantly advanced and was becoming more generally accepted. Those at the DME Open Public Meeting supported this position. In the interval since that time, however, in more closely reviewing the public positions and guidelines from nearly all of the major cardiovascular and surgical societies, support for the use of this technology is not found, even for limited use. For this reason we are not at this time adding routine coverage for PCDs for arterial disease.

1. Multiple commenters supported the extension of coverage of Pneumatic Compression Devices (PCDs) to include those for Peripheral Arterial Disease (PAD). Several commenters took the position that the LCD should include coverage of PCDs for *all* PAD, and not be restricted to those who would otherwise qualify for a surgery but were medically ineligible.
   Response: This final policy does not allow for coverage of Pneumatic Compression Devices (PCDs) for Peripheral Arterial Disease (PAD) of any severity. Further literature searches since the date of the draft release have shown no long-term studies supporting that outcomes using a PCD are comparable to the accepted standard of using a surgical revascularization where possible and no major cardiovascular or surgical societies have adopted guidelines taking this position. We received limited journal copies, anecdotal case-reports and brief series information to support the use of this technology as a temporizing or supportive measure for those with advanced disease who are otherwise ineligible for surgery, but here as well, there are no sizeable, long-term studies of efficacy. The medical directors extensively again reviewed all submitted literature as well as coverage decisions by major agencies, health service research entities and insurers (see in the LCD under **Sources of Information and Basis for Decision**). Of these, *only* *one*, from Ireland's Health Information and Quality Authority takes a position supporting any coverage, and that is equivocal, indicating "...more research is needed to confirm...a *potentially* beneficial treatment for people at risk of amputation who are not candidates for revascularization...remains unproven." After this reassessment, we have concluded it is not reasonable and necessary to add coverage of arterial peripheral compression devices (E0675) at this time.

2. Multiple commenters suggested diagnostic findings and tests that in their opinion could confirm eligible beneficiaries for PCDs for PAD as a possible alternative to attestation that the beneficiary would otherwise be a candidate for surgery.
   Response: There was little consistency to these recommendations. Had we pursued coverage of arterial compression at this time, we would have needed to continue the "otherwise be a candidate for surgery" criterion. Currently, there is no consensus on the usefulness of available diagnostic tests to demonstrate the predictive value of arterial PCD.

3. Several commenters recommended allowing coverage of an E0652 PCD for secondary lymphedema of any etiology, with or without ulcers, when diagnostic criteria are met and the E0650 or E0651 has been ineffective at controlling the lymphedema. It was recommended that documentation of trained and supported daily use of a carefully fitted E0650 or E0651 for a minimum of 4 weeks without significant clinical response should be sufficient to evidence the need for the E0652 device. It was recommended the documentation include a detailed description of the therapies recommended in conjunction with the pump as well as providing objective clinical details of why E0650/E0651 device and adjunct therapies were not effective.
   Response: The CMS National Coverage Decision (280.6) has determined, "The only time that a segmented, calibrated gradient pneumatic compression device (HCPCs code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber."

   Review of the clinical literature indicates that the *only* consistently documented clinical need for an E0652 is for the treatment of lymphedema extending onto the chest, trunk and/or abdomen past the limits of a standard compression sleeve, where the lymphedema has failed to improve with a continued, carefully-performed, good-faith trial of the E0650/E0651 device coupled with other more conservative therapy.

Commenters indicated a need to use an E0652 where an E0650/E0651 was simply incapable of the task due to conditions of severe obesity, chronicity, fibrosis, number of wounds or other reasons, but there was no literature provided to enable a systematic way to identify these rare situations. The absence of such clinical literature prevents development of criteria to identify individual clinical circumstances and they must therefore continue to be addressed at appeal by individual consideration of a record which must establish that all other more conservative approaches including the continuous, regular use of E0650/E0651 over time have proven insufficient, whereas a trial of the E0652 has been successful.

4. Several commenters raised a concern that the draft LCD conflicts with NCD 280.6 for PCDs by being more restrictive that the NCD in the coverage afforded to causes of lymphedema.
   Response: The revised LCD broadens the allowed indications and thereby specifically addresses any concern in this area. There is no conflict with the revised LCD and the NCD.
5. One commenter recommended that an inability to tolerate compression bandaging for venous ulcers should be an immediate indication for venous compression regardless of the length of time the ulcers have been present.
   Response: This is not an option for the DME MACs under NCD 280.6.
6. One commenter recommended that the six-month period of conservative therapy for venous stasis ulcers be reduced to four months. Other commenters also objected to the six-month requirement.
   Response: This is not an option for the DME MACs under NCD 280.6.
7. Several commenters recommended that PCDs should be covered for chronic venous insufficiency even in the absence of ulcers.
   Response: This is not an option for the DME MACs under NCD 280.6. However, the coverage of lymphedema from various causes has been broadened which will likely accomplish much of what these commenters desire.
8. One commenter felt the language"*...has failed to improve with a period of at least four weeks of regular daily home use of the E0650 or E0651 with careful, in-person fitting, overview and training by a technician skilled in and regularly, successfully using the appliances prescribed..*" is unclear.
   Response: The language and formatting have been clarified.
9. One commenter recommended that an E0652 be allowed for unilateral limb edema, documented to be unresponsive to use of E0651/E0650 coupled with other more conservative measures, on a prior authorization basis.
   Response: This recommendation is beyond the scope of the current LCD and Policy Article revisions.
10. One large manufacturer of PCDs recommended that part of the current focus in the NCD and LCD about usage of the E0650 and E0651 was because of price differential and that with improvements in technology and cost-efficiencies in recent years, Medicare should reduce the reimbursement for E0652 and relax requirements for use of this code.
    Response: This recommendation is beyond the scope of the current LCD and Policy Article revisions.
11. Quite a number of commenters had recommendations and/or concerns about the rapidity and duration of inflation and deflation times for arterial compression devices, indicating these are critical variables in their functional efficacy and that a number of the products on the market seeking coverage do not have comparable functional efficacy. Others had concerns that the manufacturing requirements for arterial compression devices were not adequately addressed, including a number of very detailed and well-documented observations, reports of research on various parameters and peer-reviewed articles on these topics.
    Response: Coverage of arterial compression devices (E0675) is not being added at this time.
12. Multiple commenters objected to the requirement that the ordering of an E0675 was being restricted to a vascular surgeon.
    Response: Coverage of arterial compression devices (E0675) is not being added at this time.
13. Several commenters pointed out that angiographic dye may be contraindicated in some patients and therefore alternative diagnostic methods for severity of arterial disease are necessary.
    Response: Coverage of arterial compression devices (E0675) is not being added at this time.

14. Several commenters offered recommendations and/or concerns about the recertification of the need for PCDs for arterial compression.
    Response: Coverage of arterial compression devices (E0675) is not being added at this time.
15. Several commenters indicated podiatrists should be an eligible provider type to order PCDs, rather than have ordering providers limited to physicians (MD, DO) and physician extenders (NP, PA & CNS).
    Response: Podiatrists (DPM) and other providers are excluded because applicable state scope-of-practice or other license requirements limit management of systemic conditions. Treatment of peripheral artery disease, lymphedema, chronic venous insufficiency with ulceration and complications related to the treatment of these conditions by use of PCDs, require consideration of diagnoses and management of systemic conditions that fall outside of these practitioners' license limitations.
16. One commenter indicated PCDs are very effective in his vascular surgery practice without needing to use or try more conservative measures first and on that basis they should be a first-line therapy for this condition.
    Response: The Medical Directors disagree. Many therapies and testing modalities *may* be effective for conditions which would otherwise respond to simpler, conservative measures. The logic of medical necessity indicates that such interventions should be used in series, first using simpler measures shown by accepted clinical practice to often be effective, unless there is a clear evidence basis to skip these simpler measures for the specific clinical circumstances.
17. One commenter pointed out the word "endoscopic" should be changed on page four.
    Response: We agree. The language has been changed.
18. Two commenters pointed out that the CMN for pneumatic compression pumps, CMS Form 846 (DME Form 04.04B), does not track with the NCD and LCD requirements which causes confusion in submitting claims.
    Response: We agree and are hopeful the CMN may at some point be revised to correct these issues, but this is currently beyond the scope of this LCD and Policy Article revision.

PRESSURE REDUCING SUPPORT SURFACES

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0181. The quarterly edit effectiveness results from April 2014 through July 2014 are as follows:

The E0181 review involved 259 claims, of which 152 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 64%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Medical records did not support coverage criteria
- Detailed Written Order (DWO) was incomplete and/or missing elements

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces – Group 1 Local Coverage Determination (LCD) L11578 and Policy Article A33678.

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

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

Policy Education

No documentation was received in response to ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

Medical records did not support coverage criteria.
A group 1 mattress overlay or mattress is covered if one of the following three criteria is met:

- The patient is completely immobile-i.e., patient cannot make changes in body position without assistance, or
- The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
- The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D.

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

Detailed Written Order was incomplete and/or missing element.
A DWO is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

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

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

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

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

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

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

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

The DWO must be available upon request.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0185. The quarterly edit effectiveness results from May 2014 through August 2014 are as follows:

> The E0185 review involved 268 claims, of which 208 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 77%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Medical records did not support coverage criteria
- Documentation did not contain a valid date stamp (or similar)

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces – Group 1 Local Coverage Determination (LCD) L11578 and Policy Article A33678.

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

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

Policy Education

No documentation was received in response to ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

Medical records did not support coverage criteria.
A group 1 mattress overlay or mattress is covered if one of the following three criteria are met:

- The patient is completely immobile-i.e., patient cannot make changes in body position without assistance, or
- The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
- The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D.

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):

- Impaired nutritional status
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

Documentation did not contain a valid date stamp (or similar).
A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed written order prior to delivery (WOPD) with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0277. The quarterly edit effectiveness results from May 2014 through August 2014 are as follows:

> The E0277 review involved 150 claims, of which 110 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 75%.

Top Denial Reasons

- Medical records did not support coverage criteria
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Detailed Written Order (DWO) was incomplete and/or missing elements
- Documentation did not include staging of pressure ulcer(s)

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces – Group 2 Local Coverage Determination (LCD) L11579 and Policy Article A35422.

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

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

Policy Education

Medical records did not support coverage criteria.
A group 2 support surface is covered if the beneficiary meets at least one of the following three Criteria (1, 2 or 3):

- The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02-707.05) which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:
  - Use of an appropriate group 1 support surface, and
  - Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
  - Appropriate turning and positioning, and
  - Appropriate wound care, and
  - Appropriate management of moisture/incontinence, and
  - Nutritional assessment and intervention consistent with the overall plan of care
- The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02-707.05).
- The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (ICD-9 707.02 -707.05), and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

No documentation was received in response to ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

Detailed Written Order was incomplete and/or missing element.
A DWO is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

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

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

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

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

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only

state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

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

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

The DWO must be available upon request.

Documentation did not include staging of pressure ulcer(s).
The staging of pressure ulcers used in this policy is as follows:

- Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- Stage I – Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
- Stage II – Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
- Stage III – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- Stage IV – Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.
- Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the beneficiary in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the side lying position.

REMITTANCE ADVICES

CORE 360 Uniform Use of CARCs and RARCs Rule – Update from CAQH CORE – Implement Operating Rules – Phase III ERA EFT

MLN Matters® Number: MM 8983
Related Change Request (CR) #: CR 8983
Related CR Release Date: November 26, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3135CP
Implementation Date: April 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per

Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2015, and CR8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and 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.

Background

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

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

Per 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 four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined Business Scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction for CR8983 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3135CP.pdf on the CMS website.

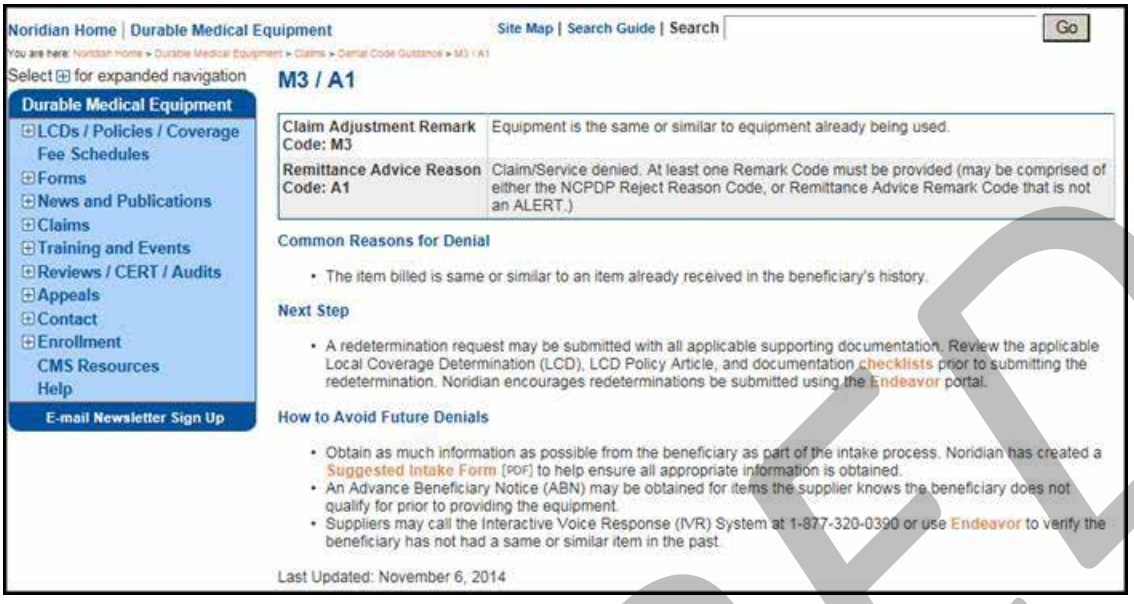
Denial Code Guidance

To help suppliers better understand why Noridian processed a claim the way we did and learn what the next steps are for the service billed, Noridian is publishing web pages for the specific denial reason and remark codes. To access these pages, visit https://www.noridianmedicare.com/dme/claims/denial_codes/index.html.

Contents of each webpage include:

- Claim Adjustment Reason Code and description as defined by the Washington Publishing Company (WPC)
- Claim Adjustment Remark Code and description as defined by the WPC
- Common reason why Noridian may process a claim using that reason or remark code
- Next steps for the particular claim (re-file as a new claim, submit a written determination, request a reopening, etc.)
- How to avoid future denials on similar claims
- Applicable resources

An image depicting an example denial code guide webpage is provided below.



Although there are only eight reason and remark codes with web page guidance published, this type of content will continue to be produced for our supplier community.

Continuous Positive Airway Devices (HCPCS E0601KH and 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 E0601 for the first month of billing (KH modifier) and the 4-13 month of billing (KJ modifier). The quarterly edit effectiveness results from April 2014 through July 2014 are as follows:

The E0601 KH review involved 2966 claims, of which 1962 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 66%.

The E0601 KJ review involved 1654 claims, of which 965 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 60%.

Top Denial Reasons

- No documentation of valid date stamp or similar for written order prior to delivery (WOPD)
- No documentation was received in response to Additional Documentation Request (ADR) letters.
- Documentation submitted did not support criterion two (objective evidence of adherence) was met for continued coverage beyond the first three months for (KJ) claims.
- No documentation of face-to-face clinical evaluation prior to the sleep test

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure Devices Local Coverage Determination (LCD) and Policy Article,

Suppliers can also review specific policy resources for Positive Airway Pressure Devices on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist Respiratory Assist Device on the Noridian website.

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

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

Policy Education

No documentation of valid date stamp or similar for WOPD
A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier's possession BEFORE the item is delivered.

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

No documentation was received in response to ADR letters.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the request documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on the Noridian Medicare website.

Documentation submitted did not support criterion two (Objective evidence of adherence) was met for continued coverage beyond the first three months for (KJ) claims.
Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

- Objective evidence of adherence to use of the PAP device, reviewed by the treating physician. Adherence to therapy is defined as use of PAP ≥4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

No documentation of face-to-face clinical evaluation prior to the sleep test.
There must be documentation to support that the beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes E0439 and E0434. The quarterly edit effectiveness results from April 2014 through July 2014 are as follows:

The **E0439** review involved 219 claims, of which 137 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 64%.

The **E0434** review involved 95 claims, of which 78 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 72%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- No documentation of valid Written Order Prior to Delivery (WOPD)
- No documentation of valid date stamp or similar for WOPD
- The proof of delivery submitted is invalid

Going Forward

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

Educational Resources

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

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist on Oxygen and Oxygen Equipment on the Noridian website.

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

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

Policy Education

No documentation was received in response to Additional Documentation Request (ADR) letters.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation **must** be available upon request.

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the request documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on the Noridian Medicare website.

No documentation of valid WOPD.
A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the DMEPOS supplier's possession BEFORE the item is delivered.

No documentation of valid date stamp or similar for WOPD.
A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

The proof of delivery (POD) submitted is invalid.

PROOF OF DELIVERY (PIM 4.26, 5.8)
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

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

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

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

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

Method 1 – Direct Delivery to the Beneficiary by the Supplier
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

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

- Date delivered
- Evidence of delivery

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

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

Oxygen (HCPCS E1390) Quarterly Results of Documentation Compliance Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code E1390, oxygen concentrator. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from June 1 through August 31, 2014, resulted in an overall error rate of 24%.

Top Denial Reasons

- Requested documentation was not received by the contractor within the allotted timeframe.
- There was no proof of delivery (POD) submitted or the POD was invalid.
- There was no documentation to support the beneficiary had been seen and evaluated by the treating physician within 30 days prior to the date of the initial Certificate of Medical Necessity (CMN).
- The documentation provided did not contain the beneficiary's most recent arterial blood gas P02 and/or oxygen saturation test.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677.

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

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

Policy Education

Documentation not received within the correct time frame.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. Section 1833(e) of the Social Security Act precludes payment to any provider of services unless there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

There was no proof of delivery (POD) submitted or the POD was invalid.
CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 5.8 states that:

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

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

For the purpose of the delivery methods noted below, designee is defined as "Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."
Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

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

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

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

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

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

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim. Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

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

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required. When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

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

There was no documentation to support the beneficiary had been seen and evaluated by the treating physician within 30 days prior to the date of the initial Certificate of Medical Necessity (CMN).
LCD L11457 Testing and Visit Requirements states that an evaluation by the treating physician, within 30 days prior to initial certification, is required when the CMN is initiated in the following instances:

- With the first claim for home oxygen, (even if the beneficiary was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO.)
- During the first 36 months of the rental period, when there has been a change in the beneficiary's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. (Please refer to the Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES for additional information.)

The documentation provided did not contain the beneficiary's most recent arterial blood gas P02 and/or oxygen saturation test.
LCD L11457 indicates the qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. These prohibitions do not extend to blood gas studies performed by a hospital certified to do such tests.

The qualifying blood gas study may be performed while the beneficiary is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test done at rest and awake is nonqualifying, but either an exercise or sleep oximetry test on the same day is qualifying, the exercise or oximetry test result will determine coverage.

All oxygen qualification testing must be performed in-person by a physician or other medical professional qualified to conduct oximetry testing. With the exception of overnight oximetry (see below), unsupervised or remotely supervised home testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment.

Claims for oxygen equipment and supplies for beneficiaries who do not meet the coverage requirements for home oxygen therapy will be denied as not reasonable and necessary.

Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0470. The quarterly edit effectiveness results from April 2014 through July 2014 are as follows:

The E0470 review involved 32 claims, of which 24 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 75%.

Top Denial Reasons

- Documentation of face-to-face clinical evaluation prior to the sleep test
- Documentation of sleep test
- Documentation of valid date stamp or similar for written order prior to delivery (WOPD)
- Documentation of instruction on proper use and care of equipment

Policy Education

There must be documentation to support that the beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

- The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
- The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
  - Hypertension, ischemic heart disease, or history of stroke.

Documentation of valid date stamp or similar for WOPD: A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the DMEPOS supplier's possession BEFORE the item is delivered.

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

Documentation of instruction on proper use and care of equipment: There must be documentation from the supplier to support the beneficiary and/or caregiver has received instruction from the supplier of the device in the proper use and care of the equipment.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure Devices Local Coverage Determination (LCD) and Policy Article.

Suppliers can also review specific policy resources for Respiratory Assist Device on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Suppliers can also review a specific policy Documentation Checklist for Respiratory Assist Device on the Noridian website.

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

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

SURGICAL DRESSINGS

Correct Coding – Surgical Dressings Containing Medical Honey

DME MAC Joint Publication

Medicinal use of honey has a long history with various health benefits ascribed to it. Recently the DME MAC Medical Directors requested information regarding the use of honey as a component in surgical dressings. We wish to thank all those who provided a response.

Historically medical honey has not been considered as a separate, covered surgical dressing component by Medicare. Dressings incorporating honey have been assigned HCPCS coding based upon the underlying covered elements. For example, an alginate dressing with honey is put into the same HCPCS codes as an alginate dressing without honey.

The DME MAC Medical Director Workgroup reviewed the clinical literature and other evidence in consideration of whether medical honey should be considered as a separate, covered component in surgical dressings. The workgroup determined that there is insufficient evidence to justify the conclusion that medical honey should be considered as a separate, covered component in surgical dressings. HCPCS coding for honey containing surgical dressings will continue as it has been in the past i.e. HCPCS coding is based upon the underlying covered components.

Refer to the Surgical Dressings Local Coverage Determination and related Policy Article for additional information about coverage and coding for surgical dressings.

TENS

Conductive Garment for Delivery of TENS or NMES (HCPCS E0731) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0731. The quarterly edit effectiveness results from May 2014 through July 2014 are as follows:

> The E0731 review involved 63 claims, of which 51 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 83%.

Top Denial Reasons

- There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.
- The written order prior to delivery does not contain the prescribing physician's National Provider Identifier (NPI) number.
- The written order prior to delivery does not contain a valid date stamp or similar.
- The documentation provided does not support coverage of a garment purchase.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) and Policy Article.

Suppliers can also review a specific policy Documentation Checklist for Transcutaneous Electrical Nerve Stimulators on the Noridian website.

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

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

Policy Education

There was no documentation submitted in response to the ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on our website.

The written order prior to delivery does not contain the prescribing physician's NPI number.

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)

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

Someone other than the ordering physician may produce the WOPD. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items
- Prescribing physician's National Provider Identifier (NPI) (*Note that only individual NPI numbers must be used. Institutional or group NPI numbers are not acceptable)
- Physician signature and signature date

The written order prior to delivery does not contain a valid date stamp or similar.
The supplier must have the properly authenticated WOPD in their files before the item is dispensed.

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

The documentation provided does not support coverage of a garment purchase.
A conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but is covered only if all of the following conditions are met:

- It has been prescribed by the treating physician for use in delivering covered TENS treatment
- One of the medical indications outlined below is met:
  - The beneficiary cannot manage without the conductive garment because
    - There is such a large area or so many sites to be stimulated and
    - The stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires
  - The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires
  - The beneficiary has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires
  - The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain.

Correct Coding – Cefaly®

Joint DME MAC Publication

The Cefaly® device (Cefaly Technology) is a transcutaneous electrical nerve stimulator (TENS) that is applied to the forehead using a self-adhesive electrode positioned bilaterally over the upper branches of the trigeminal nerve. The Cefaly® device is intended to stimulate the upper branches of the trigeminal nerve and has received Food and Drug Administration (FDA) approval for the prophylactic treatment of episodic migraine headache.

Items that serve a prevention or precautionary purpose are non-covered by Medicare. The correct code for Cefaly® is:

A9270 – Noncovered item or service.

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

TENS Device (HCPCS E0730) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0730. The quarterly edit effectiveness results from May 2014 through July 2014 are as follows:

The E0730 review involved 106 claims, of which 99 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 94%.

Top Denial Reasons

- There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.
- The documentation provided does not support usage and frequency.
- The documentation provided does not support a valid trial period.
- The documentation provided does not support pain was present for three months.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) and Policy Article.

Suppliers can also review a specific policy Documentation Checklist for Transcutaneous Electrical Nerve Stimulators on the Noridian website.

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

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

Policy Education

There was no documentation submitted in response to the ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the

consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on our website

The documentation provided does not support usage and frequency.
For chronic pain covered under criterion II, there must be information in the medical record describing:

- The location of the pain
- The severity of the pain
- The duration of time the beneficiary has had the pain
- The presumed etiology of the pain
- Prior treatment and results of that treatment
- Reevaluation of the beneficiary at the end of the trial period, must indicate
    - how often the beneficiary used the TENS unit
    - the typical duration of use each time
    - the results (effectiveness of therapy)

The documentation provided does not support a valid trial period.
For chronic pain other than low back pain:

- the trial is for a minimum of one month (30 days)
- does not exceed 2 months
- the trial period is paid as a rental
- monitored by the physician to determine effectiveness of therapy

The documentation provided does not support pain was present for three months.
Per LCD L11495, Criterion II Chronic Pain Other than Low Back Pain, TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:

- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
    - Headache
    - Visceral abdominal pain
    - Pelvic pain
    - Temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months
- Other appropriate treatment modalities must have been tried and failed

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

TENS Device, Two Lead (HCPCS E0720) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0720. The final edit effectiveness results from February, 2014 through September, 2014 are as follows:

The E0720 review involved 125 claims, of which 122 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 97%.

Top Denial Reasons

- The documentation provided does not support usage and frequency.
- There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.
- The order submitted was invalid or incomplete. Additionally, the written order prior to delivery (WOPD) submitted contained an invalid date stamp or equivalent.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for Transcutaneous Electrical Nerve Stimulators on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

Policy Education

The documentation provided does not support usage and frequency.
For chronic pain covered under criterion II, there must be information in the medical record describing:

- The location of the pain
- The severity of the pain
- The duration of time the beneficiary has had the pain
- The presumed etiology of the pain
- Prior treatment and results of that treatment
- Reevaluation of the beneficiary at the end of the trial period, must indicate
- How often the beneficiary used the TENS unit
- The typical duration of use each time
- The results (effectiveness of therapy)

There was no documentation submitted in response to the ADR letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on our website at https://www.noridianmedicare.com/dme/claims/edi.html.

The order submitted was invalid or incomplete. Additionally, the WOPD submitted contained an invalid date stamp or equivalent.
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.

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)

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

Someone other than the ordering physician may produce the WOPD. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Prescribing physician's National Provider Identifier (NPI) (*Note that only individual NPI numbers must be used. Institutional or group NPI numbers are not acceptable)
- Physician signature and signature date

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

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

The WOPD must be available upon request.

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

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires a date stamp (or similar) which clearly indicates the supplier's date of receipt of the completed WOPD with the prescribing physician's signature and signature date.

Therapeutic Shoes (HCPCS A5500) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code A5500. The quarterly edit effectiveness results from June 2014 through September 2014 are as follows:

The A5500 review involved 3,165 claims, of which 2,508 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 79%.

Top Denial Reasons

- Documentation of foot abnormalities by certifying physician not met
- Documentation of diabetes management by certifying physician not met
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation of in-person visit prior to selection of items not met

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076.

Suppliers can also review a specific policy Documentation Checklist for Therapeutic shoes on the Noridian website.

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

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

Policy Education

Documentation of foot abnormalities by certifying physician not met.
There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

- Previous amputation of the other foot, or part of either foot, or
- History of previous foot ulceration of either foot, or
- History of pre-ulcerative calluses of either foot, or
- Peripheral neuropathy with evidence of callus formation of either foot, or
- Foot deformity of either foot, or
- Poor circulation in either foot.

In order to meet criterion 2, the certifying physician must either:

- Personally document one or more of criteria a – f in the medical record of an in-person visit within six months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
- Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D. or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within six months prior to delivery of the shoes/inserts, and that documents one of more of criteria above.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

Documentation of diabetes management by certifying physician not met.
There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within six months prior to delivery of the shoes/inserts; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within three months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. **The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.**

No documentation was received in response to Additional Documentation Request letter.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon

the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on our website.

Documentation of in-person visit prior to selection of items not met.
There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.

For all shoes, taking measurements of the patient's feet.

For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

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

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

A4351: Intermittent urinary catheter, straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.) each

A4353: Intermittent urinary catheter, with insertion supplies

A4357: Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each

A4358: Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each

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

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

- Treating physician's dispensing and written order
- Medical records to support the Local Coverage Determination (LCD) policy criteria for the items billed
- Medical documentation that supports the medical necessity for use of a greater quantity of supplies than the amounts specified in the policy (if applicable)
- Proof of delivery
- Advanced Beneficiary Notice of Noncoverage (ABN) (if applicable)
- Any other supporting documentation

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

UROLOGICAL SUPPLIES

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Urological Supplies LCD L11581 and Policy Article A25377.

Additional information, educational opportunities and training tools related to this product category are available on our Training and Events page. Information about prepay reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3.

VACUUM ERECTION DEVICES

Policy Article Revision – Vacuum Erection Devices

Joint DME MAC and PDAC Publication

The DME MACs have revised the Coding Guidelines in the related Policy Article for Vacuum Erection Devices (VED). The current Coding Guidelines state:

Vacuum pumps typically draw a vacuum of less than 17 inches of mercury. If the vacuum range of a new device differs by more than +/- 10% from that specification, manufacturers must conduct studies to establish the clinical safety and efficacy of the vacuum drawn by their device. The manufacturer must perform tests to verify the maximum vacuum level.

All devices coded L7900 for reimbursement by Medicare must include a vacuum limiter such that a maximum vacuum of less than or equal to 17 inches of mercury is obtained unless manufacturers demonstrate via clinical studies establishing the clinical efficacy of the vacuum drawn by their device.

The revised Coding Guidelines state:

Vacuum pumps coded L7900 must demonstrate a capability to generate a negative pressure in the range of greater than 3.9 and less than 17 inches of mercury (100 and 432 mmHg, respectively). All devices coded L7900 for reimbursement by Medicare must include a vacuum limiter such that a maximum vacuum of less than 17 inches of mercury (432 mmHg) is obtained. The manufacturer must perform tests to verify the maximum vacuum level.

The DME MACs will be publishing this revised language in an upcoming revision of the policy.

As a reminder, effective for dates of service on or after 11/01/2014, only products that have been reviewed by the Pricing, Data Analysis and Coding (PDAC) contractor and assigned code L7900 and L7902 are reimbursable by Medicare. Products which have not undergone coding verification review by the PDAC must be coded A9270. The revised Coding Guideline product specifications will be applied to products submitted for review.

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

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L7900. The quarterly edit effectiveness results from May 2014 through August 2014 are as follows:

The L7900 review involved 430 claims, of which 229 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 54%.

Top Denial Reasons

- Documentation submitted did not support the medical necessity of the item ordered.
- No documentation was received in response to Additional Documentation Letters (ADR).
- Same/similar item has already been billed, paid and delivered to the beneficiary.
- No office notes or medical records were submitted to support coverage criteria.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the National Coverage Determination for Diagnosis and Treatment of Impotence NCD 230.4, CMS Publication 100-8, Program Integrity Manual (PIM) Chapter 5 and the Supplier Manual Chapter 3. For services performed on or after August 1, 2014 the Vacuum Erection Devices (VED) Local Coverage Determination (LCD) L34736 and Policy Article A52677.

Suppliers can also review a specific policy Documentation Checklist for Vacuum Erection Devices on the Noridian website.

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

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

Policy Education

Documentation did not support medical necessity.
The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by Medicare, the beneficiary's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity off items ordered and for the frequency of use or replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. There must be information in the beneficiary's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)".

For services performed on or after August 1, 2014:

- A vacuum erection device (L7900) and tension ring (L7902) are covered for the treatment of erectile dysfunction (ED) secondary to organic impotence (see Diagnosis Codes section in related Policy Article) if all of criteria 1 – 3 are met:
- The beneficiary has an in-person clinical evaluation with their treating physician within six (6) months prior to ordering the VED; and,
- The beneficiary has no evidence of symptomatic or untreated hypogonadism or hyperprolactinemia and,
- Other treatment options have been tried or considered and ruled out, and the result (if tried) or contraindication (if considered) must be clearly documented in the beneficiary's medical record.

If any of criteria 1 – 3 are not met, L7900 and related supplies (L7902) will be denied as not medically necessary.

The physician ordering the VED and related supplies must be a physician treating the beneficiary for the disease or condition justifying the need for the VED.

Vacuum erection devices and related supplies will be denied as non-covered in situations involving temporary impairments.

Policy Specific Documentation Requirements
For criteria 1 and 2 in the **Coverage Indications, Limitations, and/or Medical Necessity** section, the physician must document in the medical record a beneficiary's sexual, medical and psychosocial history. This in-person clinical evaluation must include a physical examination focused on an assessment of the genitourinary, endocrine, vascular and neurologic systems and include, at a minimum, a genital and rectal examination, to rule out reversible causes of ED.

For criterion 3 in the **Coverage Indications, Limitations, and/or Medical Necessity** section, the medical record must address the following alternative treatment options:

- If clinically appropriate, modification or discontinuation of medications contributing to ED (e.g., anti-hypertensives, anti-depressants, anxiolytics, etc.);
- The use of phosphodiesterase type 5 (PDE-5) inhibitors, intracavernous injections or intraurethral prostaglandins.

No documentation was received in response to ADR letters.
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Suppliers Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on our website.

The same or similar item was already billed, paid and delivered to the beneficiary.
The DME MACs and DME Program Safeguard Contractors (PSCs) shall establish appropriate safeguards to assure that payments are not made beyond the last month of medical necessity. They must develop appropriate safeguards to identify and investigate the following:

- Multiple claims for rental of the same or similar equipment from the same supplier within the same rental month (e.g., rental claims with different start dates but within the same rental period); Pub. 100-04, chapter 20, §30.5 specifically forbids payments for multiple claims for rental of the same or similar equipment from either the same or a different supplier during the same rental month.
- Contraindicated items of rented or purchased equipment;
- Incompatible claims information (e.g., liquid oxygen contents billed for a purchased gas delivery system);
- Medical equipment rentals or purchases after a beneficiary's death;
- Rental start dates on or after the purchase of the same or comparable equipment (absent evidence that the beneficiary has disposed of purchased equipment);
- Rental claims for the same or similar equipment from different suppliers for the same or overlapping rental months; and
- Equipment rental start dates within periods of confinement in an institution that cannot be considered a patient's home.

No office notes or medical records were submitted to support coverage criteria.
Section 1833 (e) of the Social Security Act precludes payment to any provided of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

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