DME Happenings

Jurisdiction D
Issue No. 42
March 2014

In This Issue...

FYI

ABN

APPEALS

BILLING

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Noridian Healthcare Solutions, LLC

CERT

CMS MLN CONNECTS

COMPETITIVE BIDDING

CPM DEVICES

DOCUMENTATION

DRUGS & BIOLOGICALS

EDUCATIONAL

EFT

ENROLLMENT

ENTERNAL NUTRITION

ESRD

GLUCOSE MONITORS

HOSPITAL BEDS

HOME HEALTH

ICD-10

INCARCERATED BENEFICIARIES

LCD AND POLICY ARTICLE REVISIONS

MOBILITY DEVICES

NEBULIZERS

ORTHOTICS AND PROSTHETICS

OXYGEN

PAP DEVICES

PECOS

PRESSURE REDUCING SUPPORT SURFACES

REFILLS

REPAIRS

REIMBURSEMENT

REMITTANCE ADVICE

RADS

RESPIRATORY

SPEECH GENERATIVE DEVICES

TENS

THERAPEUTIC SHOES

VACUUM ERECTION DEVICES

Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	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

2013 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Event	Date	Closure Timeframe
Off-the-Phone Training	April 11, 2014	9:30 a.m. – 12 p.m. CT
Good Friday	April 18, 2014	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	April 25, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 9, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 16, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 23, 2014	9:30 a.m. – 12 p.m. CT
Memorial Day	May 26, 2014	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	June 13, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 20, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 27, 2014	9:30 a.m. – 12 p.m. CT
Independence Day	July 4, 2012	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	July 11, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 18, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 25, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 8, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 15, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 22, 2014	9:30 a.m. – 12 p.m. CT

Event	Date	Closure Timeframe
Labor Day	September 1, 2014	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	September 12, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 19, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 26, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 10, 2014	9:30 a.m. – 12 p.m. CT
Columbus Day Training	October 13, 2014	2:00 p.m. – 6 p.m. CT
Off-the-Phone Training	October 17, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 24, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	November 14, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	November 21, 2014	9:30 a.m. – 12 p.m. CT
Thanksgiving	November 27 and 28	Entire Day Closed 8 a.m. – 6 p.m. CT
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, 2012	12 – 6 p.m. CT
Christmas	December 25, 2012	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 20, 2013	9:30 a.m. – 12 p.m. CT
Christmas	December 24, 2013	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Christmas	December 25, 2013	Entire Day Closed 8 a.m. – 4:30 p.m. CT
New Year's Day	January 1, 2014	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	January 3, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	January 10, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	January 17, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	January 24, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	February 7, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	February 14, 2014	9:30 a.m. – 12 p.m. CT
President's Day Training	February 17, 2014	2:00 p.m. – 4:30 p.m. CT
Off-the-Phone Training	February 21, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	February 28, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	March 7, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	March 14, 2014	9:30 a.m. – 12 p.m. CT

Event	Date	Closure Timeframe
Off-the-Phone Training	March 21, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	March 28, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	April 4, 2014	8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	April 11, 2014	9:30 a.m. – 12 p.m. CT
Good Friday	April 18, 2014	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	April 25, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 2, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	May 9, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 16, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 23, 2014	9:30 a.m. – 12 p.m. CT
Memorial Day	May 26, 2014	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	June 6, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	June 13, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 20, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 27, 2014	9:30 a.m. – 12 p.m. CT
Independence Day	July 4, 2012	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	July 11, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 18, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 25, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 1, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	August 8, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 15, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 22, 2014	9:30 a.m. – 12 p.m. CT
Labor Day	September 1, 2014	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	September 5, 2014	8:30 a.m. – 10 a.m. CT
Off-the-Phone Training	September 12, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 19, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 26, 2014	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 3, 2014	8:30 a.m. – 10 a.m. CT
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Thanksgiving	November 27 and 28	Entire Day Closed 8 a.m. – 4:30 p.m. CT

Event	Date	Closure Timeframe
Off-the-Phone Training	December 5, 2014	8:30 a.m. – 10 a.m. CT
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	12 – 4:30 p.m. CT
Christmas	December 25, 2014	Entire Day Closed 8 a.m. – 4:30 p.m. CT

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 – RailroadRetirement 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.
- 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.

CMS Requests Feedback on MLN Matters

Your feedback is important to us as we use your suggestions to improve the quality of MLN Matters® articles so they better meet your educational needs. To provide feedback on MLN Matters® articles, we encourage you to submit your feedback online. Your participation is strictly anonymous, and it will only take a few minutes to complete.

You may also evaluate MLN Matters® articles, by visiting http://go.cms.gov/MLNMattersArticles and clicking on the 'MLN Opinion Page' link under 'Related Links.' From that page, click on the 'MLN Evaluations' link under 'Related Links,' and select 'MLN Matters Articles' from the list of products. After you have completed the evaluation, click on 'Submit.'

HETS to Replace CWF Medicare Beneficiary Health Insurance Eligibility Queries

MLN Matters® Number: SE1249 Revised

Note: This article was revised on February 10, 2014, to update certain language to reflect the current status of this change (see bolded language on page 2). Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare's Common Working File (CWF) queries to obtain their patient's Medicare health insurance eligibility information from Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)).

Provider Action Needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

What You Need to Know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the Multi-Carrier System (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. Change Request 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date. This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare Contractor's Interactive Voice Response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's Health Care Eligibility Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key Points

General Information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help web page at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html on the CMS website.

Frequently Asked Questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare Contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: Health Insurance Claim Number (HICN), Medicare Beneficiary's Date of Birth, Medicare Beneficiary's Full Last Name (including Suffix, if applicable), and Medicare Beneficiary's Full First Name. The Date of Birth and First Name are optional, but at least one must be present.

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF. When these changes are made, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. These changes will be in place before the termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

- Part D plan number, address and enrollment dates.
- Medicare Advantage Organization name, address, website and phone number.

The HETS 270/271 Companion Guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf on the CMS website.

Additional Information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1-866-324-7315.

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."

Modifying Daily CWF to Medicare Beneficiary Database File to Include Diagnosis Codes on HETS 270/271 Transactions

MLN Matters® Number: MM8456 Revised
Related Change Request (CR) #: CR 8456
Related CR Release Date: March 6, 2014
Related CR Transmittal #: R1356OTN
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Note: This article was revised on March 7, 2014, to reflect a revised Change Request (CR). The revise CR changes the effective and implementation dates. 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 Home Health & Hospice (HH&H) MACs and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8456, which informs Medicare contractors about changes to the Medicare Beneficiary Database (MBD) File to include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare Secondary Payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the Common Working File (CWF) MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers' compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional Information

The official instruction, CR8456 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.pdf on the CMS website.

President Obama Signs the Pathway for SGR Reform Act of 2013 – New Law Includes Physician Update Fix through March 2014

On December 26, 2013, President Obama signed into law the Pathway for SGR Reform Act of 2013. This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014. President Obama remains committed to a permanent solution to eliminating the Sustainable Growth Rate (SGR) reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.

The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies have been extended. We also have included Medicare billing and claims processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 1101 – Medicare Physician Payment Update – As indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through March 31, 2014. CMS is currently revising the 2014 Medicare Physician Fee Schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2014 conversion factor is $35.8228.

Section 1102 – Extension of Medicare Physician Work Geographic Adjustment Floor – The existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2014. As with the physician payment update, this extension will be reflected in the revised 2014 MPFS.

Section 1103 – Extension Related to Payments for Medicare Outpatient Therapy Services – Section 1103 extends the exceptions process for outpatient therapy caps through March 31, 2014. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through March 31, 2014. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD). Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2014. For physical therapy and speech language pathology services combined, the 2014 limit for a beneficiary on incurred expenses is $1,920. There is a separate cap for occupational therapy services which is $1,920 for 2014. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 1103 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2014 through March 31, 2014, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 1104 – Extension of Ambulance Add-On Payments – Section 1104 extends the following two Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through March 31, 2014; and (2) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus) is extended through March 31, 2014. The provision relating to air ambulance services that continued to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, expired on June 30, 2013.

Section 1105 – Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals – The Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges from the hospital. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through March 31, 2014, retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Section 1106 – Extension of the Medicare-Dependent Hospital (MDH) Program – The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until March 31, 2014, and is retroactive to October 1, 2013. Be on the alert for further information about implementation of this provision.

Recalcitrant Provider Procedures

MLN Matters® Number: MM8394
Related Change Request (CR) #: CR 8394
Related CR Release Date: December 13, 2013
Effective Date: January 15, 2014 – This process is currently in effect and this is a clarification through a manual update.
Related CR Transmittal #: R495PI
Implementation Date: January 15, 2014

Provider Types Affected

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

What You Need To Know

The CR that this article refers to how MACs will address recalcitrant providers and suppliers. The Centers for Medicare & Medicaid Services (CMS) has learned from contractors that some providers are abusing the Medicare program and not changing inappropriate behavior even after contractors provide them extensive education to address these behaviors. These noncompliant providers who refuse to comply with CMS rules, result in contractors' placing these providers on prepay medical review and causing an administrative burden.

Background

Over the years, CMS has heard from Medicare contractors that some providers are abusing the Medicare program; and, even after extensive educational efforts, do not change their inappropriate behavior.

Notes: In this context

1. Providers are defined as both providers and suppliers, under their current definitions found in the Code of Federal Regulations (CFR) at 42 CFR, Section 400.202).
2. Recalcitrant providers are defined as those who abuse the Medicare program and do not change their inappropriate behavior even after their Medicare contractors have given them extensive provider education addressing these behaviors.

The behavior of these recalcitrant providers who refuse to comply with CMS requirements has resulted in their being placed on prepay medical review for long periods of time, requiring the extensive use of contractor resources; that (while, indeed, protecting Trust Fund dollars) would be better utilized for other types of more productive oversight activity.

Accordingly, CMS is encouraging contractors to take advantage of current sanctions to address this problem of recalcitrant providers. The two authorities that may be appropriate to impose such a sanction are 1128A (a)(1)(E) of the Social Security Act (the Act), or 1128(b)(6)of the Act; which you can find at http://www.ssa.gov/OP_Home/ssact/title11/1128.htm on the internet. Both of these sanctions are delegated to the Office of the Inspector General (OIG), who will work with CMS to pursue these cases.

CR 8394, from which this article is taken, updates chapter 4 Section 4.27 of the "Medicare Program Integrity Manual" by adding a section formalizing the process for addressing recalcitrant providers and suppliers.

Note: Any provider referred as a potential recalcitrant provider case should be an "outlier," meaning a provider who has been the least receptive to changing and has a significant history of non-compliance. For any case submitted, it is important to remember that different mitigating or aggravating circumstances may need to be applied.

Additional Information

The official instruction, CR 8394, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R495PI.pdf on the CMS website. You will find the updated "Medicare Program Integrity Manual," Chapter 4 (Benefit Integrity), Section 27 (Recalcitrant Providers) as an attachment to that CR.

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.

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
11	Benefits Coordination and Recovery Center	Updated address for written inquiries	02/28/14
11	Coordination of Benefits	Changed to Benefits Coordination & Recovery Center (BCRC)	02/18/14
Appendix	Acronyms	Added Benefits Coordination & Recovery Center (BCRC)	02/18/14
5	Purchase option of capped rental items	Added calculation	01/31/14
6	CMS-1500 Claim Form	Added information on 1500 form	01/31/14
1	What is Medicare	Removed Medicare + Choice	01/16/14
1	Noridian' Role as a DME MAC	Updated information for contracts	01/16/14
6	Time Limit for Filing Claims	Removed date table	01/16/14
17	Claim Development Procedures	Updated sample letter	01/16/14
15	Voluntary Refunds	Changed address for refunds	12/19/13
13	Federal Court Review	Updated amount in controversy for 2014	12/04/13
9	Advance Determination of Medicare Coverage for Customized DME	Updated the HCPCS codes that are eligible for ADMC	11/14/13

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.

Updated Mobile Applications (Apps) for Open Payments

MLN Matters® Number: SE1402

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to alert the provider community of updates to the mobile applications (apps), Open Payments Mobile for Industry and Open Payments Mobile for Physicians, implemented as a result of user feedback to CMS. See the Background and Key Points sections of this article for details.

Also, a part of SE1402 is new technical documentation: "The Open Payments QR Code Reader How-To Guide." Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

Background

In July 2013, CMS released two mobile apps: Open Payments Mobile for Industry and Open Payments Mobile for Physicians. Below are enhancements to the original Open Payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the Welcome screen.
- Adding the ability to export all profile data associated with a payment into CSV format.
- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html on the CMS website. For help with the apps contact the CMS helpdesk at OpenPayments@cms.hhs.gov.

Key Points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the Google Play™ app store or iOSApple™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for Open Payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

Enhancement Topic	Details – What It Does
Changes that Apply to Both Apps (Open Payments Mobile for Industry and Open Payments Mobile for Physicians)	
Streamlined "Welcome" screen options	• A number of infrequently used menu options (e.g., "Program Information" and "Change Password") moved from the "Welcome" screen and now appear in a hidden menu. • To access the menu, swipe to the right at the "Welcome" screen.
Reports/Statistics	• A new "Reports/Statistics" button, accessible on the "Welcome" screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within Open Payments Mobile for Industry) or vendor (within Open Payments Mobile for Physicians). • This new chart creation capability will streamline data review.
CSV exporting	• When payment data is exported via CSV format, all profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.). • The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process.
Streamlined "Add Payment" process	• The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the "Add Payment" menu. • The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the "Add Payment" menu.

Enhancement Topic	Details – What It Does
Easy payment duplication	• A new button available on the "View Payment" screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment. • The only data field that needs to be re-entered is the date.
Vendors/Physicians sorted alphabetically	• In "Manage Vendors/Physicians," vendors or physicians are now listed alphabetically. • The prior app version listed vendors and physicians in the order in which they were entered.
Email/print QR code added	• A "Share" button is available to email or print a QR code that is generated within the app, for sharing at a later time.
Payment QR code warning added	• After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code.
Additional data elements added in "Add Payment" > "Travel & Lodging"	• When nature of payment in "Add Payment" is "Travel & Lodging," the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it).
Tablet support	• Both apps are optimized for viewing on tablet devices.
Changes that Apply to Just One App Open Payments Mobile for Physicians	
"Manage Companies" added	• Within "Manage Vendors", a new data field allows users to assign vendors to companies when entering new vendor information. • Company information is needed for the "Reports/Statistics" functionality to illustrate all payments by company name.

The updated Frequently Asked Questions about the mobile apps contain all the details about these enhancements (link to the document above, or visit the "Apps for Tracking Assistance" page on the Open Payments website).

QR Code Technical Guide Available for Apps: Also now available to support use of the Open Payments apps is a how-to-guide that explains the technical details associated with how to create Quick Response (QR) codes usable in the apps. "The Open Payments QR Code Reader How-To Guide" includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user's devices.

To review "The Open Payments Mobile Application Quick Response (QR) Code Reader Documentation: A How-To Guide to Create Java Script Object Notation (JSON) QR Code" referenced in this SE1402, see http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-QR-Code-Reader-How-To-Guide-%5bDecember-2013%5d.pdf on the CMS website.

To review the series of SE articles leading up to SE1402 see the following:

1. MLN Matters® SE1303 "Information on the National Physician Payment Transparency Program: Open Payments," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf on the CMS website.
2. MLN Matters® SE1329 "Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)" is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf on the CMS website.

MLN Matters® SE1330 "Open Payments: An Overview for Physicians and Teaching Hospitals" may be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1330.pdf on the CMS website.

Correction CR – ABN, Form CMS-R-131

MLN Matters® Number: MM8597
Related Change Request (CR) #: CR 8597
Related CR Release Date: February 14, 2014
Related CR Transmittal #: R2878CP
Effective Date: May 15, 2014
Implementation Date: May 15, 2014

Provider Types Affected

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

What You Need to Know

This article, based on Change Request (CR) 8597, provides the removal of language that was erroneously included in CR8404 and in the "Medicare Claims Processing Manual," Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

Key Points of CR8597

- With the exception of Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.
- An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is now available for download at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.
- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the "Additional Information" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your Medical Assistance plan will pay for this care." HHAs may also use the "Additional Information" on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.
- Some States have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. **Note:** If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.

- HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the State's Medicaid directive. If the HHA's State Medicaid office does **not** want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the "Additional Information" box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

Additional Information

The official instruction, CR8597, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2878CP.pdf on the CMS website.

Redeterminations: Helpful Hints

Suppliers are encouraged to use the following help hints when submitting redeterminations to decrease the number of unprocessable requests.

1. All redetermination requests received via hard copy through mail courier or facsimile must contain a signature of the person filing the request. If the redetermination form is not signed, the request will be dismissed. This may result timely filing issues of future requests. Electronic signatures are only accepted on requests filed through Noridian's Endeavor portal. (Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions, Section 310.1.B.3, Filing a Request for Redeterminations)
2. One request form per beneficiary and issue is allowed.
3. Suppliers must use the IVR (877-320-0390) or Endeavor (https://www.noridianmedicare.com/dme/claims/endeavor.html) for claim status or appeals status inquiries.
4. Do not use this form for Medicare Secondary Payer (MSP) or general written inquiries.
5. Supplier address changes must be initiated through the National Supplier Clearinghouse (NSC).
6. If a redetermination decision has been received regarding the issue, do not submit another redetermination. A reconsideration is the next step of appeal.
7. When submitting a redetermination, attach the required documentation, which may include written orders, proof of delivery, relevant medical records, etc. Reasonable and necessary denials must include a copy of the Advance Beneficiary Notice of Noncoverage (ABN) signed by the beneficiary, if available.

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

APPEALS

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.

BILLING

DMEPOS – 2014 HCPCS Code Jurisdiction List

MLN Matters® Number: MM8565
Related Change Request (CR) #: CR 8565
Related CR Release Date: January 24, 2014
Related CR Transmittal #: R2861CP
Implementation: February 25, 2014

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs (formerly carriers) for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8565 to notify suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, carrier, or B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS codes appearing on the spreadsheet. The spreadsheet for the 2014 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html on the CMS website. It is also attached to CR8565

Additional Information

The official instruction, CR 8565 issued to your DME MAC, or A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2861CP.pdf on the CMS website. The Excel® spreadsheet for the 2014 Jurisdiction List is also attached to CR8565.

Appropriate Usage of the KK Modifier

Per information from the Competitive Bidding Implementation Contractor (CBIC) and CMS, the KK modifier must be used to identify when the same supply or accessory is furnished in multiple competitive bidding product categories for Round 1 and Round 1 Rebid. Based on the Round 1 and Round 1 Rebid competitive bid categories, the only items that fall under multiple competitive bidding product categories are wheelchair accessories used on standard power wheelchairs and scooters and those accessories used on complex rehabilitative power wheelchairs. Therefore, the KK modifier is designated for use on Round 1 and Round 1 Rebid competitive bid (CB) claims to indicate CB accessories used with Complex Rehabilitative Power Wheelchairs bid in Round 1 and Round 1 Rebid.

In addition, the KK modifier should only be used on claims for beneficiaries who live in a Competitive Bidding Area. Therefore, the KK modifier should not be used on any type of DMEPOS, other than accessories in the competitive bid program used on complex rehabilitative power wheelchairs. Inappropriate use of the KK modifier will result in an unprocessable claim denial for inappropriate modifier usage. The remark code will be N519: Missing/incomplete/invalid HCPCS modifier.

As a reminder the dates for Round 1 claims and Round 1 rebid claims are as follows. These dates reflect dates of service.

- Round 1: July 1–14, 2008
- Round 1 Rebid: January 1, 2011 – December 31, 2013

For more information see:

- MLN Matters Article SE1305
- CBIC article on Appropriate Usage of Modifiers KG, KK and KL

CMS 1500 Claim Form Instructions: Revised for Form Version 02/12

MLN Matters® Number: MM8509
Related Change Request (CR) #: CR 8509
Related CR Release Date: December 27, 2013
Effective Date: January 6, 2014
Related CR Transmittal #: R2842CP
Implementation Date: January 6, 2014

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.
- On and after April 1, 2014, Medicare will no longer accept claims on the old CMS 1500 claim form, 08/05.

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/R2842CP.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).

Common Errors on 02/12 Paper Claim Form

The CMS-1500 claim form has been updated to accommodate ICD-10 requirements. The revised version (02/12) has had several modifications that if not addressed may result in claim denials or improper payment. Below are common errors we are seeing on paper claims.

Item 17 Name of Referring Provider or Other Source

One of the new additions to the paper claim form is a Provider Qualifier. This Qualifier is found on the left side of Item 17, left of the dotted vertical lines (shown as XX below). Make sure when printing the Provider Qualifier and Provider Name in Item 17 that an appropriate space is left between data. Printing the Provider Qualifier to the right of the dotted vertical line or the Provider's Name to the left of the vertical line could cause inaccurate processing.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		
XX JOHN SMITH MD	17b.	NPI	1234567899

Appropriate Provider Qualifiers to be used in Item 17 are:

DK – Ordering Provider (this is the appropriate qualifier for DME claims)

DN – Referring Provider

DQ – Supervising Provider

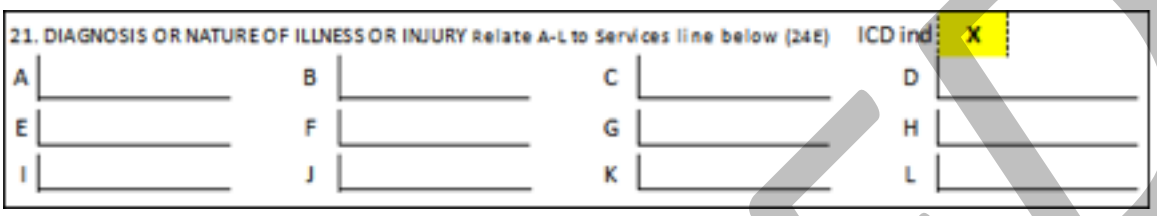
Item 21 Diagnosis or Nature of Illness or Injury

This item has a couple of format changes, starting with the addition of the ICD Indicator. The ICD Indicator can be found in the upper right portion of Item 21 (shown as X below). The ICD indicator must be present and must reflect the type of diagnosis submitted in Item 21. Failure to do so will result in claim processing delays.

Appropriate ICD Indicators are:

9 – ICD 9 CM Diagnosis

0 – ICD 10 CM Diagnosis



Providers now have the ability to list up to 12 diagnosis codes in Item 21. Diagnosis codes should not contain decimals points or spaces. Descriptions or other extraneous information should not be included.

Note: The new format of the 02/12 claim form as it is unlike the formatting found on the old 1500 (08/05) form. Diagnosis codes are listed from left to right instead of top to bottom. Make sure the pointer references the correct diagnosis for that claim line.

Item 24E Diagnosis Pointer

Previously, this item required a 1, 2, 3 or 4 to indicate the primary diagnosis found in Item 21. This has changed to a single letter that indicates the diagnosis found in Item 21. Use one letter from A to L as the diagnosis pointer on the claim line. Multiple characters or numeric characters in Item 24E could delay the processing of the claim.

Helpful Hints to Improve Claim Processing

- Use a Legible Font – Use a size 10 or 12 font in Courier New style, making sure information is properly aligned on the form.
- Remove all Staples – Remove all staples, paper clips, or binder clips from claims and attachments. These items may prevent the scanner from properly imaging the claim and corresponding attachments as well as slow down their processing.
- Remove all Sticky Notes and Stickers – Sticky notes and stickers are often used to convey additional information but often cover information needed for the processing of the claim resulting in additional processing time. Avoid using sticky notes and stickers. Any additional information about the claim should be included on an attachment.
- Don't Highlight Information – Although highlighting information is intended to make elements on a claim stand out, it has the reverse affect. When scanned, this information cannot be processed as it appears to be blacked out. Do not use highlighters on paper claims.
- Refrain from Extraneous Information – Extraneous information on the claim adds additional time to the processing of a claim. Extraneous information can include but is not limited to: descriptions after a diagnosis code, descriptions after a procedure code, any stamped information such as "Corrected Claim" in Item 24, addresses in the margins around the claim form, circling information or using an arrow to indicate important information.
- Use the Correct Mailing Address – Using the address that is appropriate for the claim will assist in timely processing. Mailing the claim to the incorrect address can cause delays in processing or possible denials. If Part B, DME, and/or Part A claims need to be submitted, do not submit them in the same envelope. Include only one type of claim per envelope.

Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims

MLN Matters® Number: SE1344
Related Change Request (CR) #: CR 8401
Related CR Release Date: October 30, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: 2805
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is related to CR 8401, which requires, effective January 1, 2014, the mandatory reporting of a clinical trial identifier number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the "Medicare National Coverage Determination (NCD) Manual," Section 310.1.

The clinical trial identifier number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. Thank is the number assigned by the Nation Library of Medicine (NLM) http://clinicaltrials.org website when a new study appears in the NLM Clinical Trials data base.

Since the release of CR 8401, the Centers for Medicare & Medicaid Services (CMS) has learned that some physicians, providers, and suppliers do not have the capability at this time to submit the clinical trial identifier number associated with trial-related claims. This article presents those physicians, providers, and suppliers with an alternative means of satisfying the CR 8401 requirements until January 1, 2015. At that time, such providers must fully comply with CR 8401. Make sure that your billing staffs are aware of the requirement and the implementation changes and dates.

Background

CMS understands that implementing CR 8401 by January 1, 2014, would create an undue hardship on a number of its stakeholders. As a result, for physicians, providers, and suppliers who do not have the capacity at this time to report the clinical trials identifier number associated with trial-related claims, CMS is providing an option to submit a generic number in place of the actual National Clinical Trials (NCT) number.

Beginning January 1, 2014, and continuing no later than through December 31, 2014, those above-mentioned physicians, providers, and suppliers may instead report an 8-digit, generic number of 99999999 using the instructions in CR 8401. This will allow trial-related claims to process appropriately if they are prepared according to instructions in CR 8401. Keep in mind that trial-related claims will be returned if they do not contain either the actual clinical trial identifier number or the 8-digit generic number 99999999 – you may not leave those indicated fields blank. That said, CMS encourages those affected by CR 8401 to update their internal claims processing procedures as expeditiously as possible so they can begin reporting the actual clinical trial identifier number as CR 8401 instructs.

Note: This in no way precludes those already reporting and/or able to report the actual clinical trial number on clinical trial-related claims from doing so. Beginning January 1, 2015, without further notice, CR 8401 shall be fully implemented.

Note: For clarification, the clinical trial identifier number is required for all items/services provided in relation to participation in a clinical trial, clinical study, or registry that may result from coverage with evidence development (CED), the Medicare Clinical Trial Policy, or a CMS-approved investigational device exemption (IDE) study. For IDE trials, both the IDE and the clinical trial identifier number are required. Specifically, include the clinical trial identifier number if: the beneficiary is enrolled in an approved clinical trial; AND, the claim is for the investigational item or service, AND/OR, the costs are related to the investigational item or service, AND/OR, the costs are related to routine care for the condition in the clinical trial.

Additional Information

The official instruction, CR 8401, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf on the CMS website. The MLN Matters® article related to CR 8401 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf on the CMS website.

Section 310.1 of the "Medicare National Coverage Determination (NCD) Manual" is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

HCPCS Code Update – 2014

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2014.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2014.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2013, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2014.

There is no grace period that would allow submission of the discontinued code for dates of service in 2014.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2014.

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

Ankle-Foot/Knee-Ankle-Foot Orthosis

Added Code	
Code	**Narrative**
L4361	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4387	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, OFF-THE-SHELF

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L1902	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, OFF-THE-SHELF
L1904	ANKLE FOOT ORTHOSIS, MOLDED ANKLE GAUNTLET, CUSTOM-FABRICATED	ANKLE ORTHOSIS, ANKLE GAUNTLET, CUSTOM-FABRICATED
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF
L1907	AFO, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS, CUSTOM FABRICATED	ANKLE ORTHOSIS, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS, CUSTOM FABRICATED
L4350	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID, INCLUDES ANY TYPE INTERFACE (E.G. , PNEUMATIC, GEL), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID, INCLUDES ANY TYPE INTERFACE (E.G., PNEUMATIC, GEL), PREFABRICATED, OFF-THE-SHELF
L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4370	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, OFF-THE-SHELF
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4398	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, OFF-THE-SHELF

Immunosuppressive Drugs

Added Code	
Code	**Narrative**
J7508	TACROLIMUS, EXTENDED RELEASE, ORAL, 0.1 MG

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
J7507	TACROLIMUS, ORAL, PER 1 MG	TACROLIMUS, IMMEDIATE RELEASE, ORAL, 1 MG

Intravenous Immune globulin

Added Code	
Code	**Narrative**
Q2052	SERVICES, SUPPLIES AND ACCESSORIES USED IN THE HOME UNDER THE MEDICARE INTRAVENOUS IMMUNE GLOBULIN (IVIG) DEMONSTRATION

Knee Orthoses

Added Code	
Code	**Narrative**
L1812	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, OFF-THE-SHELF
L1833	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, OFF-THE SHELF
L1848	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, OFF-THE-SHELF

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, OFF-THE-SHELF
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L1836	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S), INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S), INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1850	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICATED, OFF-THE-SHELF

Lower Limb Orthotics

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INIDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUA WITH EXPERTISE

Lower Limb Prostheses

Added Code	
Code	**Narrative**
L5969	ADDITION, ENDOSKELETAL ANKLE-FOOT OR ANKLE SYSTEM, POWER ASSIST, INCLUDES ANY TYPE MOTOR(S)

Manual Wheelchair Bases

Added Code	
Code	**Narrative**
K0008	CUSTOM MANUAL WHEELCHAIR/BASE (effective 7/1/2013)

Miscellaneous

Added Code	
Code	**Narrative**
A4555	ELECTRODE/TRANSDUCER FOR USE WITH ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, REPLACEMENT ONLY
E0766	ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES, ANY TYPE
K0900	CUSTOMIZED DURABLE MEDICAL EQUIPMENT, OTHER THAN WHEELCHAIR (effective 7/1/2013)

Oral Antiemetic Drugs

Added Code	
Code	**Narrative**
Q0161	CHLORPROMAZINE HYDROCHLORIDE, 5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
Q0165	PROCHLORPERAZINE MALEATE, 10 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0164
Q0168	DRONABINOL, 5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0167
Q0170	PROMETHAZINE HYDROCHLORIDE, 25 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0169
Q0171	CHLORPROMAZINE HYDROCHLORIDE, 10 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0161
Q0172	CHLORPROMAZINE HYDROCHLORIDE, 25 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0161
Q0176	PERPHENAZINE, 8MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0175
Q0178	HYDROXYZINE PAMOATE, 50 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0177

Orthopedic Footwear

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT	HALLUS-VALGUS NIGHT DYNAMIC SPLINT, PREFABRICATED, OFF-THE-SHELF
L3170	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, EACH	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, PRAFABRICATED, OFF-THE-SHELF, EACH

Ostomy Supplies

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
A5081	CONTINENT DEVICE; PLUG FOR CONTINENT STOMA	STOMA PLUG OR SEAL, ANY TYPE

Oxygen and Oxygen Equipment

Added Code	
Code	**Narrative**
E1352	OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE

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

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE

Power Mobility Devices

Added Code	
Code	**Narrative**
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR BASE (effective 7/1/2013)

Spinal Orthoses: Cervical, TLSO and LSO

Added Code	
Code	**Narrative**
L0455	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0457	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0467	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF
L0469	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF
L0641	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

Added Code

Code	Narrative
L0642	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0643	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0648	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0649	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0650	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0651	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

Narrative Changes

Code	Old Narrative	New Narrative
L0120	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM COLLAR)	CERVICAL, FLEXIBLE, NON-ADJUSTABLE, PREFABRICATED, OFF-THE-SHELF (FOAM COLLAR)
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT, PREFABRICATED, OFF-THE-SHELF
L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO PIECE	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO-PIECE, PREFABRICATED, OFF-THE-SHELF

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION, PREFABRICATED, OFF-THE-SHELF
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, OFF-THE-SHELF
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/ PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/ PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0980	PERONEAL STRAPS, PAIR	PERONEAL STRAPS, PREFABRICATED, OFF-THE-SHELF, PAIR
L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4)	STOCKING SUPPORTER GRIPS, PREFABRICATED, OFF-THE-SHELF, SET OF FOUR (4)
L0984	PROTECTIVE BODY SOCK, EACH	PROTECTIVE BODY SOCK, PREFABRICATED, OFF-THE-SHELF, EACH

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
L0430	SPINAL ORTHOSIS, ANTERIOR-POSTERIOR-LATERAL CONTROL, WITH INTERFACE MATERIAL, CUSTOM FITTED (DEWALL POSTURE PROTECTOR ONLY)	NONE

Suction Pumps

Added Code	
Code	**Narrative**
A7047	ORAL INTERFACE USED WITH RESPIRATORY SUCTION PUMP, EACH

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
A9272	MECHANICAL WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, EACH	WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, ANY TYPE, EACH

Upper Limb Orthotics

Added Code

Code	Narrative
L3678	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, OFF-THE-SHELF, ANY TYPE
L3916	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3918	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED, OFF-THE-SHELF
L3924	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3930	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, OFF-THE-SHELF

Narrative Changes

Code	Old Narrative	New Narrative
L3650	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, PREFABRICATED, OFF-THE-SHELF
L3660	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, OFF-THE-SHELF
L3670	SHOULDER ORTHOSIS, ACROMIO/ CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, ACROMIO/ CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, OFF-THE-SHELF
L3675	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, OFF-THE-SHELF
L3677	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3710	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINTS, PREFABRICATED, OFF-THE-SHELF

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L3762	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, OFF-THE-SHELF
L3912	HAND FINGER ORTHOSIS, FLEXION GLOVE WITH ELASTIC FINGER CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND FINGER ORTHOSIS (HFO), FLEXION GLOVE WITH ELASTIC FINGER CONTROL, PREFABRICATED, OFF-THE-SHELF
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3925	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L3927	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G. STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G. STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Wheelchair Options/Accessories

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM	WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE
E2301	POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM	WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM, ANY TYPE

Healthcare Provider Taxonomy Codes Update, April 2014

MLN Matters® Number: MM8611
Related Change Request (CR) #: CR 8611
Related CR Release Date: February 28, 2014
Related CR Transmittal #: R2888CP
Effective Date: April 1, 2014
Implementation Date: July 7, 2014 (Contractors with the capability to do so will implement April 1, 2014)

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Claims Administration Contractors (Fiscal Intermediaries (FIs), carriers, A/B Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHIs), Home Health and Hospices (HHHs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8611, from which this article is taken, instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Both the current Accredited Standards Committee (ASC) X-12 837 institutional and professional Technical Report Type 3 (TR3s) require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standard implementation guides state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code."
- "If not required by this implementation guide, do not send."

Note: Medicare does not use HPTCs to adjudicate its claims and would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC set.

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. See http://aspe.hhs.gov/admnsimp/final/txfin00.htm on the Internet. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HTPC set is maintained by the NUCC for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

CR 8611 implements the NUCC HPTC code set that is effective on April 1, 2014, and instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

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

Additional Information

The official instruction, CR 8611 issued to your carriers, FIs, A/B MACs, RHHIs, HHHs, and DME MACs, regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2888CP.pdf on the CMS website.

Indirect Payment Procedure – Payment to Entities that Provide Coverage Complementary to Medicare Part B

MLN Matters® Number: MM8638
Related Change Request (CR) #: CR 8638
Related CR Release Date: March 7, 2014
Related CR Transmittal #: R2896CP
Effective Date: June 6, 2014
Implementation Date: June 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and other applicable entities submitting claims using the indirect payment procedure to Part B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

What You Need to Know

The article is based on Change Request (CR) 8638, which updates the manual instructions regarding the indirect payment procedure policy in the "Medicare Claims Processing Manual," Chapter 1, Section 30.2.8.3.

Section 1842(b)(6)(B) of the Social Security Act, as well as the Medicare regulations at 42 Code of Federal Regulations (CFR) Section 424.66, specify that payment may be made to an entity for Part B services furnished by a physician or other supplier under a complementary health benefit plan if the entity meets certain requirements. This process is known as the indirect payment procedure (IPP).

According to Chapter 1, Section 30.2.8.3 of the "Medicare Claims Processing Manual", because Section 1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" as described in 42 CFR. 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95 percent of the physician fee schedule amount.

Payment under the IPP can only be made for covered Part B services. If an IPP entity submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his/her claim), then Medicare cannot make payment to the physician for that same service. Medicare payment can only be made once for a beneficiary's specific service. Therefore, claims for services that have already been billed to Medicare shall be denied (with appeal rights) by Medicare's contractors.

In addition, Medicare payment cannot be made under the IPP for services that are payable for a particular beneficiary under any other Part of Medicare. For example, if a beneficiary's service is payable under Part C and a Medicare Advantage organization is also an IPP entity under 42 CFR 424.66, then a Medicare Part B payment under the IPP cannot be made to that Medicare Advantage organization for that beneficiary's service. In these types of dual or multiple enrollment situations, services that are payable under those other Parts of Medicare (e.g., Parts C or D) cannot also be billed and paid for under Part B. Therefore, IPP entities that submit Part B claims for services that are payable under another Part of Medicare (e.g., Part C or D) shall be denied (with appeal rights) by Medicare's contractors.

Payment for IPP claims by Medicare is conditioned upon the claim and the underlying transaction complying with the Medicare laws, regulations, and program instructions applicable to IPP entities, and on the IPP entity's continued compliance with the regulatory requirements described in 42 CFR 424.66.

Medicare's IPP policy states that Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

1. Provides coverage of the service under a complementary health benefit plan (that is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).
2. Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.
3. Has the written authorization of the beneficiary or of a person authorized to sign claims on the beneficiary's behalf under 42 CFR 424.36 to receive the Part B payment for the services for which the entity pays.
4. Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, or from the beneficiary's survivors or estate.
5. Submits any information the Centers for Medicare & Medicaid Services (CMS) or the MAC may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.
6. Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that satisfy all of the requirements above may include employers, unions, insurance companies, and retirement homes. They also may include health care prepayment plans, health maintenance organizations (HMOs), competitive medical plans, and Medicare Advantage organizations.

The IPP permits a physician or supplier to file a single claim with the complementary insurer and receive full payment in a single payment, relieves the beneficiary of the need to file a claim, and protects the beneficiary against any financial liability for the service.

In addition, any entity wishing to bill using the IPP must register through Provider Enrollment and meet such requirements specified in the "Medicare Program Integrity Manual," Chapter 15, Sections 15.7.9 through 15.7.9.7. This part of the manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf on the CMS website.

Additional Information

The official instruction, CR 8638, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2896CP.pdf on the CMS website.

Modifying Daily CWF to Medicare Beneficiary Database File to Include Diagnosis Codes on HETS 270/271 Transactions

MLN Matters® Number: MM8456 Revised
Related Change Request (CR) #: CR 8456
Related CR Release Date: March 6, 2014
Related CR Transmittal #: R1356OTN
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Note: This article was revised on March 7, 2014, to reflect a revised Change Request (CR). The revise CR changes the effective and implementation dates. 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 Home Health & Hospice (HH&H) MACs and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8456, which informs Medicare contractors about changes to the Medicare Beneficiary Database (MBD) File to include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare Secondary Payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the Common Working File (CWF) MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers' compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional Information

The official instruction, CR8456 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.pdf on the CMS website.

New Claim Form Must Be Submitted on April 1, 2014

The CMS-1500 claim form has been updated for ICD-10. Form Version 02/12 will replace the CMS 1500 claim form, 08/05, effective for claims received on and after April 1, 2014.

Below are key dates for compliance with the claim submission rules:

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

The grace period for suppliers to transition to the new form expires on April 1, 2014. Suppliers need to plan ahead to ensure that claims submitted on the "old" 08/05 claim form mailed or sent via a courier service reach the Noridian offices located in Fargo, ND by March 31, 2014. Claims on the "old" claim form received on/after April 1, 2014 will not be processed. Suppliers will receive a letter stating that the incorrect form was submitted and that they will need to submit the claims on the current, 02/12 version of the paper claim form.

Note: Updating the print layout for the new claim form will require fairly significant adjustments. The revised form, version 02/12, has a number of revisions which require changes to the print layout for proper data alignment.

Those most notable changes to the 02/12 claim form are for Items 17, 21 and 24E.

Item 17 must have a qualifier entered to the left of the dotted vertical line in Item 17 to indicate the type of provider being reported in this field, as outlined below:

- DN – Referring Provider
- DK – Ordering Provider (this is the appropriate qualifier for DME claims)
- DQ – Supervising Provider

Item 21 now allows for 12 diagnosis codes, rather than 4 and the diagnosis pointers have changed from 1-4 to A-L. In addition, the diagnosis codes are now read left to right, rather than up and down.

Item 24E now requires the corresponding alphabetic, rather than numeric, diagnosis pointer. See Item 21.

Suppliers are encouraged to start their claim form transition now, by updating your print layouts and obtaining the new claim form for testing. Proper preparation and testing will ensure your ability to properly submit claims on the new form by April 1, 2014.

For more information, see the following:

- MLN Matters Article 8509
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8509.pdf
- 1500 Instructions for 02/12 Version
  https://www.noridianmedicare.com/dme/claims/cms1500_02-12_instructions.html

New Non-Physician Specialty Code for IPP Billers

MLN Matters® Number: MM8282
Related Change Request (CR) #: CR 8282
Related CR Release Date: June 12, 2013
Related CR Transmittal #: R2721CP and R221FM
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

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

Provider Action Needed

Effective October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will use physician specialty code C2 as the primary and/or secondary specialty code for the Indirect Payment Procedure (IPP) billers. IPP billers should self-designate their Medicare specialty on the appropriate Form CMS-855 application when they register in the Medicare program. Specialty codes are used by CMS for programmatic and claims processing purposes.

Background

Certain health benefit plans furnish Medicare complementary coverage for their members. If such an entity qualifies as an IPP biller under 42 CFR section 424.66[i], which may be viewed at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec424-66.pdf, it may seek payment in the Medicare Fee-For-Service program for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier. CR 8282 announces that CMS established a new non-physician specialty code of C2 (Indirect Payment Procedure), effective October 1, 2013. The Provider Enrollment, Chain and Ownership System (PECOS) and MACs will recognize and use this new specialty code.

Additional Information

The official instruction, CR 8282 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2721CP.pdf on the CMS website. A related transmittal that updates the "Medicare Financial Management Manual" is http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R221FM.pdf on the CMS website.

Part B Claims Submission Under IPP

MLN Matters® Number: MM8266
Related Change Request (CR) #: CR 8266
Related CR Release Date: January 22, 2014
Effective Date: For claims processed on or after January 1, 2014
Related CR Transmittal #: R2860CP
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for entities submitting paper claims under the Indirect Payment Procedure (IPP) to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8266, which establishes a process for Indirect Payment Procedure (IPP) entities to submit paper claims for qualified Part B expenditures, including physician services, supplier services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

This article describes the process established for IPP entities to submit paper claims for qualified Part B expenditures for claims processed on or after January 1, 2014.

- IPP claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including drugs administered via DME, will continue to be processed by the DME MACs.
- IPP claims for other Part B services, including drugs administered incident to a physician service, will continue to be processed by the Part B MACs.

IPP entities are generally required to adhere to standard Medicare policies and procedures that would apply to a physician or other supplier billing for a Part B item or service. Therefore, such IPP entities are expected to know and comply with the relevant Medicare Fee-For-Service policies and procedures, which may be found in the "CMS Internet Only Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html and such applicable updates commonly published by CMS as transmittals, which may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

- IPP entities and their billing staffs should be aware that CR8266 directs Medicare contractors to implement the framework needed within the Medicare claims processing system to handle IPP claims.
- You may not begin submitting claims until you are registered and approved to submit IPP claims.
- Watch for a separate CR which will outline the registration process for IPP entities.

Background

The process by which the CMS accepts and processes claims submitted by entities that provide coverage complementary to Medicare Part B is called the Indirect Payment Procedure (IPP). If an entity:

1. Meets all of the requirements of the regulation at 42 Code of Federal Regulations (CFR) Section 424.66,
2. Is registered as an "IPP entity" in accordance with the instructions in "Medicare Program Integrity Manual," Pub. 100-08, Chapter 15, Section 15.7.9 through 15.7.9.7, and
3. Submits claims in accordance with the specifications of CR8266, then Medicare may pay that IPP entity for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier

Although the IPP differs in many respects from the direct payment process, the most important features of Medicare Part B coverage policy, Fee-For-Service payment policy, Fee-For-Service billing procedures, and related matters adhere to the same Medicare Part B standards to which direct billers are subject. Accordingly, CR8266 focuses mostly on the differences that the IPP requires and on eliminating potential ambiguities that the IPP might generate.

Though CR8266 implements the framework needed within the claims processing system to handle IPP claims, IPP entities may not begin submitting claims until they are registered and approved to submit IPP claims. Implementation of the registration process for IPP entities will be handled in a separate CR.

Medicare Policy for IPP Entities

Because IPP entities do not meet the definition of a "health care provider" (as described in 45 CFR Section 160.103), such entities are not eligible for a National Provider Identifier (NPI). Therefore, in order to facilitate the submission of IPP entities claims, IPP entities must apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) as specified by 45 CFR Section 162.

For more information on the HPID and the OEID, go to http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html on the CMS website.

Policies and procedures applicable to claim submission by, and payment to, IPP entities will be different in several aspects from those normally applied to physicians and other suppliers that bill directly for Part B items and services. These IPP-specific policies and procedures follow.

General Policies

1. The IPP is available only to an entity that: (1) meets all of the requirements of the regulation at 42 CFR Section 424.66; (2) is registered as an IPP entity in accordance with the instructions in the "Medicare Program Integrity Manual," Chapter 15, Sections 15.7.9 through 15.7.9.7; and (3) submits IPP claims in accordance with the terms of CR8266.
2. An IPP entity that submits claims under the IPP is subject to standard Medicare policies and procedures, including but not limited to Medicare Part B coverage policies, payment policies, billing procedures, and related policies and procedures except as specified in this Transmittal and all other applicable CMS directives.
3. In the event of an actual or perceived conflict between standard Medicare Part B processes and IPP, the specifications of CR8266 and any other IPP-specific CRs that may be issued in the future will govern the IPP.
4. IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. (Section 1842(h)(1) of the Social Security Act permits only "physicians and suppliers" to enter into participation agreements; an IPP entity does not meet the definition of a "supplier" as described in 42 CFR section 400.202.) Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95% of the physician fee schedule amount.
5. An IPP entity may choose to file IPP claims for only some items and services, or for some enrollees, or a combination thereof.

Coverage and Payment Policies

1. All payments to IPP entities shall be made in accordance with general Medicare Fee-For-Service coverage and payment policies.
2. No payment shall be made to IPP entities for any item or service that is not covered by Medicare Part B on the Date of Service (DOS).
3. No payment shall be made for any item or service furnished by a physician or other supplier that was not, on the DOS, enrolled in Medicare in the applicable specialty required or permitted for furnishing the item or service.
4. No payment shall be made to an IPP entity for any item or service furnished to an individual who was not entitled to, and enrolled in, Medicare Part B as a beneficiary for the DOS.

5. No payment shall be made to an IPP entity for any item or service if payment is prohibited because a statutory exclusion applies or if payment is otherwise barred under any applicable statutory or regulatory standard.
6. No payment shall be made for any item or service furnished by a "provider", as that term is defined in 42 C.F.R. Section 400.202.
7. No incentive payment shall be made to an IPP entity. Such payments include, but are not necessarily limited to, the following incentive payments: Health Professional Shortage Area (HPSA), Primary Care Incentive Payment (PCIP), HPSA Surgical Incentive Payment (HSIP), e-Prescribing, Physician Quality Reporting Systems (PQRS), and Electronic Health Records (EHR).
8. IPP entities must accept assignment on all IPP claims.
9. Medicare Secondary Payer rules apply. Medicare will not make payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim.
10. Medicare payment can only be made once for a beneficiary's particular service. If an IPP entity submits a claim for a beneficiary's service that has already been billed to and paid by Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to and paid by Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his claim), then Medicare cannot make payment to the physician for that same service.

IPP Billing and Claims Processing Policies

1. Standard claims submission and processing rules will generally apply to IPP billing. The IPP entity must submit claims that conform to Medicare requirements for physicians and other suppliers except as noted in CR8266. Clarifications and exceptions to standard Medicare claims submission and processing rules are noted below.
2. Standard claims filing jurisdiction rules apply to IPP billing. As such, the location of the IPP entity is irrelevant to establishing claims filing jurisdiction.
    - Claims for most Part B services, including drugs administered incident to a physician service, will generally be processed by MACs. Claims filing jurisdiction for such claims is based on the location where the service was performed, i.e., where the physician or other supplier performed the service.
    - Claims for most DMEPOS items and supplies, including drugs administered via DME, will generally be processed by the DME MACs. Claims filing jurisdiction for most DMEPOS claims is based on the location where the beneficiary permanently resides. Claims for some items of DME, such as implantable devices, must be submitted to the same MAC to which the surgical service claim was submitted. (Although IPP entities are generally permitted to submit some claims under the IPP but not others, if the IPP entity elects to submit a claim for an implantable device under the IPP, the IPP entity must also submit the related surgical claim. Otherwise, the claim for the implanted device will be denied.) CMS publishes an annual DMEPOS jurisdiction list that indicates the claims filing jurisdiction for items of DMEPOS.
3. Standard claims completion and submission rules generally apply to IPP billing. Exceptions are as follows:
    - The IPP entity must submit all IPP claims on the paper claim form CMS-1500 until such time as an electronic claims submission process is established for IPP claims. MACs will reject and return-as-unprocessable all IPP claims submitted on any other form or in any other format.
    - The IPP entity must, on all IPP claims, include its name and address in Item 33 of the CMS-1500.
    - The IPP entity must include its HPID or OEID in Item 33b of the CMS-1500, preceded by qualifier "XV". For example, if an IPP entity has an OEID of 2222222222, then the value entered in Item 33b should be "XV2222222222."
    - The IPP entity must annotate its Tax Identification Number (TIN) in Item 25 of the CMS-1500.
    - The IPP entity must include the NPI of the rendering physician or supplier in Item 24J of the CMS-1500.
    - The IPP entity must include the name and NPI of the ordering or referring physician in Item 17 of the CMS-1500.

- The IPP entity must not submit an IPP claim, except a DMEPOS claim, until it is registered as an IPP entity with the appropriate MAC that has claims filing jurisdiction for the IPP claim. The IPP entity must not submit an IPP DMEPOS claim until it is registered as an IPP entity with the National Supplier Clearinghouse (NSC), at which time the IPP entity may file a DMEPOS claim to the DME MAC having jurisdiction for adjudicating such a claim. Once registered, the IPP entity may file any IPP claim that predates the effective date of its registration as an IPP entity provided the claims meet the timely filing rule specified in 42 CFR Section 424.44.

4. Standard claims processing rules generally apply to IPP billing. The specifications of the business requirements in CR8266 are controlling, but the following are noted for emphasis.
   - MACs shall reject and return-as-unprocessable an IPP claim that is submitted with missing, incomplete, or invalid information, including but not limited to the information specified in paragraph 3, above.
   - MACs shall append demonstration code "70" to all IPP claims upon receipt. IPP claims shall be identified by the presence of an HPID or OEID belonging to a registered IPP entity in Item 33b of the CMS-1500 claim form.

Medicare Secondary Payer & Coordination of Benefits

1. Medicare Secondary Payer (MSP) rules apply. Medicare will not make primary payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim. MACs will inform beneficiaries regarding the applicability of MSP to IPP initial determinations via Medicare Summary Notice (MSN) message 29.35.
2. IPP claims are excluded from the National Coordination of Benefits Agreement (COBA) crossover process.

Additional Information

The official instruction, CR8266 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2860CP.pdf on the CMS website.

Registration of Entities Using IPP

MLN Matters® Number: SE1406

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended for entities that may register for indirect payment of claims submitted to Medicare contractors (A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs)) for services furnished to Medicare beneficiaries.

What You Need to Know

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or other supplier who charges on a Fee-For-Service (FFS) basis may be paid to an entity under the IPP.

This SE article outlines the Indirect Payment Procedure (IPP) registration process for these entities.

Make sure that your billing staffs are aware of the IPP registration process.

Background

Medicare Part B payment otherwise payable to a beneficiary for the services of a physician or other supplier who charges on a Fee-For-Service basis may be paid to an entity under the IPP if the conditions described in 42 CFR § 424.66 are met.

Under 42 CFR § 424.66, Medicare may pay an "IPP entity" (such as an employer, union, insurance company, retirement home, health care prepayment plan, health maintenance organization, competitive medical plan, or Medicare Advantage plan) for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

1. Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

2. Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.
3. Has the written authorization of the beneficiary (or of a person authorized to sign claims on his/her behalf under 42 CFR § 424.36) to receive the Part B payment for the services for which the entity pays.
4. Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his/her survivors, or estate.
5. Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program; and
6. Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

You can find 42 CFR Section 424.66 at http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec424-66/content-detail.html.

As an illustration, suppose an entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims.

It is important to note that an IPP entity is not a Medicare provider or supplier, is not eligible for a National Provider Identifier, and cannot enroll in the Medicare program. Nevertheless, it is crucial that Medicare obtain sufficient background information on prospective IPP entities to help ensure the integrity, accuracy, and legitimacy of Medicare payments. Such entities will therefore be required to complete the IPP registration process described below (and in more detail in CR 8284) before they can submit claims via the IPP. CMS will apply the Form CMS-855 process to IPP entities consistent with CMS' authority to request information under 42 CFR § 424.66.

Contractor Jurisdiction

Claims for all Part B items and services - other than for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - must be submitted to the A/B MAC based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides; however, claims for Medicare-covered implantable devices (although classified as DME) are submitted to the A/B MAC based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to the submission of registration applications.

Registration Process

To register as an IPP entity, you must:

1. Complete and submit:
   - A paper Form CMS-855B application to each A/B MAC to which you intend to submit claims.
   - A paper Form CMS-855S application to the National Supplier Clearinghouse (NSC) if you intend to submit claims to a DME MAC.
2. Complete and submit a paper Form CMS-588 (Electronic Funds Transfer (EFT) Agreement) with your Form CMS-855 application.
3. Submit with each Form CMS-855 application an attestation statement signed by an "authorized official" (as that term is defined in 42 CFR § 424.502) certifying that for each claim you submit, all of the requirements of 42 CFR § 424.66 are met. The certification statement on the Form CMS-855 supplements (but does not supplant) the attestation. An IPP entity is bound by the terms of the Form CMS-855 certification statement to the same extent it is bound by the attestation's terms.

Note: Since you may be submitting applications in multiple MAC jurisdictions, it is acceptable to submit a photocopy of a signed attestation rather than an originally signed attestation.

4. Apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID), furnish it in the appropriate section of the Form CMS-855, and submit actual issuance documentation with each Form CMS-855 application (for example, an issuance notice from the HPID or OEID that includes the number). See CMS' main website at http://www.cms.hhs.gov for information on how to obtain a HPID or OEID.
5. You need not:
    - Submit licensure or certification information.
    - Report medical record storage information.
    - Pay an application fee.
    - Submit a Form CMS-460 (Medicare Participating Physician or Supplier Agreement).
    - Meet the DMEPOS (i) supplier standards, (ii) accreditation requirements, (iii) surety bond requirements, or (iv) liability insurance requirements.

Processing of Registration Applications

Upon receipt of your Form CMS-855 registration application, the Medicare contractor will begin processing it. This includes:

- Ensuring that the application is complete.
- Verifying the information on the application.
- Ensuring that the attestation described above is submitted, signed by an authorized official, and contains the required language.
- As needed, asking you for additional or clarifying information to determine whether you are in compliance with the provisions of 42 CFR § 424.66 and all other requirements. It is important that you furnish such information to the Medicare contractor promptly. Failure to do so may result in the rejection of your application.
- Assigning the appropriate specialty code.

If the Medicare contractor and CMS determine that you meet all requirements, the Medicare contractor will (1) establish an effective date of registration, (2) send you an approval letter via regular mail or e-mail, and (3) assign a Provider Transaction Identification Number (PTAN). Please note that after you are registered as an IPP entity, the Medicare contractor (consistent with 42 CFR § 424.66(a)) may request additional information to confirm your continued compliance with all requirements. Moreover, an IPP entity is required to submit to the Medicare contractor all changes to its Form CMS-855 information in accordance with the terms of its signed Form CMS-855 certification statement.

If the Medicare contractor and CMS determine that you do not meet all requirements, your application will be denied. You will receive a letter outlining (1) the specific reason(s) for the denial and (2) your appeal rights.

Additional Information

Please review CR8284 for more detailed information regarding the registration process. CR8284 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R502PI.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.

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.

MLN Connects™ Provider e-News

November 14, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-14-eNews.pdf

MLN Connects™ National Provider Calls

- Streamlined Access to PECOS, EHR, and NPPES – Last Chance to Register.
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 – Registration Now Open.

MLN Connects™ Videos

- MLN Connects™ Videos on ICD-10.

CMS Events

- Learn More About Open Payments Registration and Data Submission in Upcoming Webinar.

Announcements

- Grandfathering Notices for DMEPOS Competitive Bidding Round 1 Recompete Due November 18.
- Reassigning Benefits Using the Internet-based PECOS System.
- Learn When EHR Payment Adjustment for Medicare Eligible Hospitals Begin.
- Review Important Payment Adjustment Information for Medicare EPs.
- Request a Review of 2012 PQRS Participation Results.
- Identify How ICD-10 Will Affect Your Practice.

Claims, Pricers, and Codes

- Pilot ICD-10 IOCE Code Lists Now Available for Public Comment.
- ICD-10 MS-DRG Software and Reimbursement Mappings Now Available.
- FY 2014 Inpatient Prospective Payment System Pricer File Update 3 – Revised.

MLN Educational Products

- "Skilled Nursing Facility Prospective Payment System" Fact Sheet – Revised.
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet – Reminder.
- MLN Products Available In Electronic Publication Format.

November 21, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-21-eNews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Last Chance to Register.
- CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule – Registration Now Open.
- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 – Register Now.
- Clarification from November 15 Call on the I&A System.

CMS Events

- eHealth Summit.

Announcements

- Recognizing Lung Cancer Awareness Month and the Great American Smokeout.
- Diabetes and Seasonal Influenza Vaccination.
- Updated Incarcerated Beneficiary Claim Denial FAQs.
- Learn More about PQRS and 2013 Program Participation with the New PQRS Fact Sheet.
- ICD-10: Less Than One Year Out.
- Hospitals Must Attest by November 30 to Receive Payment for 2013 EHR Incentive Program Participation.

MLN Educational Products

- "Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services" MLN Matters® Article – Revised.
- "The DMEPOS Competitive Bidding Program: Grandfathering Requirements for Non-Contract Suppliers" Fact Sheet – Revised.
- "Hospital Reclassifications" Fact Sheet – Revised."Quick Reference Information: Medicare Immunization Billing" Educational Tool – Revised.
- Updated MLN Matters® Search Indices.

- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists.
- Submit Feedback on MLN Educational Products.
- MLN Products Available In Electronic Publication Format.

November 27, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-27-eNews-PDF.pdf

MLN Connects™ National Provider Calls

- CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule - CE Credit Available.
- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 – Register Now.
- CMS Events.
- Provider Webinar on 2014 CMS eHealth Program Milestones for EPs.

Announcements

- November is National Home Care and Hospice Month.
- In Observance of World AIDS Day – Remember HIV Screenings.
- Access Your 2012 eRx Incentive Program Feedback Report Today.
- Learn How to Avoid the 2015 PQRS Payment Adjustment.
- Hospitals: Attest by November 30 to Receive EHR Incentive Payment for 2013 Participation.
- Learn More about Health Information Exchange in Stage 2 with New EHR tipsheet for Eligible Professionals.
- Stay Informed: New and Updated FAQs for the EHR Incentive Programs.
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines.

MLN Educational Products

- "Vaccine Payments Under Medicare Part D" Fact Sheet – Released.
- MLN Products Available in Electronic Publication Format.
- New MLN Provider Compliance Fast Fact.

MLN Connects™ Provider e-News Special Edition – November 27, 2013

CMS Finalizes Physician Payment Rates for 2014

Final Rule Focuses on Improved Care Coordination

On November 27, CMS finalized payment rates and policies for 2014, including a major proposal to support care management outside the routine office interaction as well as other policies to promote high quality care and efficiency in Medicare. CMS' care coordination policy is a milestone, and demonstrates Medicare's recognition of the importance of care that occurs outside of a face-to-face visit for a wide range of beneficiaries beginning in 2015. The final rule sets payment rates for physicians and non-physician practitioners paid under the Medicare Physician Fee Schedule for 2014 and addresses the policies included in the proposed rule issued in July. CMS projects that total payments under the fee schedule in 2014 will be approximately $87 billion.

As part of CMS' continuing effort to recognize the critical role primary care plays in providing care to beneficiaries with multiple chronic conditions, beginning in 2015, the agency is establishing separate payments for managing a patient's care outside of a face-to-face visit for practices equipped to provide these services.

The 2014 payment rates increase payments for many medical specialties with some of the greatest increases going to providers of mental health services including psychiatry, clinical psychologists and clinical social workers.

CMS is finalizing a process to adjust payment rates for test codes on the Clinical Laboratory Fee Schedule (CLFS) based on technological changes. Currently, the payment rates for test codes on the CLFS do not change once they have been set (except for changes due to inflation and other statutory adjustments). This review process will enable CMS to pay more accurately for laboratory tests on the CLFS.

The final rule also includes several provisions regarding physician quality programs and the Physician Value-Based Payment Modifier (Value Modifier). As CMS continues to phase-in the Physician Value – Based Payment Modifier, for 2016 CMS is finalizing its proposals to apply the Physician Value Modifier to groups of physicians with 10 or more eligible professionals, and to apply upward and downward payment adjustments based on performance to groups of physicians with 100 or more eligible professionals. However, only upward adjustments based on performance (not downward adjustments) will be applied to groups of physicians with between 10 and 99 eligible professionals.

CMS also is finalizing several related proposals to the Physician Quality Reporting System (PQRS) for 2014, including a new option for individual eligible professionals to report quality measures through qualified clinical data registries. In 2014, quality measures will be aligned across quality reporting programs so that physicians and other eligible professionals may report a measure once to receive credit in all quality reporting programs in which that measure is used. Additionally, CMS is better aligning PQRS measures with the National Quality Strategy and meaningful use requirements, and transitioning away from process measures in favor of performance and outcome measures. Finally, certain data collected in 2012 for groups reporting certain PQRS measures under the Group Practice Reporting Option (GPRO) will be publicly reported on the CMS Physician Compare website in 2014.

"Aligning measures across quality programs focuses providers on the most important measures and makes it easier to participate in programs like PQRS, which are designed to emphasize quality for Medicare beneficiaries," said Dr. Patrick Conway, CMS Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer.

Full text of this excerpted CMS press release (issued November 27).

- Final Rule
- Fact Sheet: Final Policy and Payment Changes to the Medicare Physician Fee Schedule for CY 2014
- Fact Sheet: Changes for CY 2014 Physician Quality Programs and the Value-Based Payment Modifier
- Physician Fee Schedule
- Physician Value-Based Payment Modifier
- PQRS

CMS Makes Outpatient Facility Policy and Payment Changes

Rule would give hospitals and ASCs flexibility to lower per-case costs

On November 27, CMS released a final CY 2014 hospital outpatient and ambulatory surgical center (ASC) payment rule [CMS-1601-FC] that will give hospitals and ASCs new flexibility to lower outpatient facility costs and strengthen the long-term financial stability of Medicare. In addition, CMS will replace the current five levels of hospital clinic visit codes for both new and established patients with a single code describing all outpatient clinic visits. A single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources involved in supporting an outpatient visit. The current five levels of outpatient visit codes are designed to distinguish differences in physician work.

Provisions in the final Hospital Outpatient Prospective Payment System (OPPS) rule encourage more efficient delivery of outpatient facility services by packaging the payment for multiple supporting items and services into a single payment for a primary service similar to the way Medicare pays for hospital inpatient care. Supporting items and services that will be included in a single payment for a primary service to the hospital and not paid separately include drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure; drugs and biologicals that function as supplies when used in a surgical procedure, including skin substitutes; certain clinical diagnostic laboratory services; certain procedures that are never done without a primary procedure (add-ons); and device removal procedures.

The CY 2014 final rule with comment period increases overall payments for hospital outpatient departments by an estimated 1.7 percent. The increase is based on the projected hospital market basket - an inflation rate for goods and services used by hospitals - of 2.5 percent, minus both a 0.5 percent adjustment for economy-wide productivity and a 0.3 percentage point adjustment required by statute. The rule also updates partial hospitalization payment rates for hospitals and community mental health centers.

As part of this broader proposal to consolidate payment for larger groups of services, the final rule with comment period also establishes an encounter-based or "comprehensive" payment for certain device-related procedures like cardiac stents and defibrillators, but in a change from the proposed rule, delays its effective date to 2015.

Full text of this excerpted CMS press release (issued November 27).

- Final Rule.
- Fact Sheet.

CMS Extends 2014 Annual Participation Enrollment Period through January 31

The 2014 Annual Participation Enrollment Program allows eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2013. Due to the later than usual release of the Medicare Physician Fee Schedule Final Rule, CMS is extending the 2014 annual participation enrollment period through January 31, 2014. Therefore, participation elections and withdrawals must be post-marked on or before January 31, 2014. The effective date for any participation status changes elected by providers during the extension remains January 1, 2014

Updated Information about Incarcerated Beneficiary Claim Denial Corrections

CMS has a new web page focused on the 2013 claims denials associated with a beneficiary's incarceration status.

December 5, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-05-Enews.pdf

MLN Connects™ National Provider Calls

- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 – Register Now.
- Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius – Registration Now Open.
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule – Registration Now Open.
- Did You Miss This MLN Connects Call?

CMS Events

- Special Open Door Forum: Final Rule CMS-1599-F: Hospital Inpatient Admissions.
- Hospice Item Set Training – Save the Date.

Announcements

- National Influenza Vaccination Week – December 8–14.
- Provider Enrollment Application Fee Amount.
- Deadline for Physician-owned Hospitals to Report Ownership and Investment Information Extended to March 1.
- CMS Announces Quality Strategy.
- New Short-Term Acute Care PEPPER Released.
- Reporting Period for EPs in the EHR Incentive Programs Ends December 31.

MLN Educational Products

- "Improve Your Patients' Health with the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)" MLN Matters® Article – Released.

- "Medical Privacy of Protected Health Information" Fact Sheet – Released.
- "Vaccine Payments Under Medicare Part D" Fact Sheet – Released.
- "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet – Revised.
- "The DMEPOS Competitive Bidding Program: Traveling Beneficiary" Fact Sheet – Revised.
- "The DMEPOS Competitive Bidding Program: Referral Agents" Fact Sheet – Revised.
- "The DMEPOS Competitive Bidding Program: Enteral Nutrition" Fact Sheet – Revised.
- "Communicating With Your Medicare Patients" Fact Sheet – Revised.
- "DMEPOS Quality Standards" Booklet – Reminder.
- "Medicare Coverage of Imaging Services" Fact Sheet – Reminder.
- New MLN Educational Web Guides Fast Fact.
- Submit Your Feedback on the MLN Learning Management System and Product Ordering System.

December 12, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-12-Enews.pdf

MLN Connects™ National Provider Calls

- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 – Last Chance to Register.
- Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius – Last Chance to Register.
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule – Register Now.
- Did You Miss This MLN Connects Call?

CMS Events

- ICD-10 Training Webinar Video: Navigating ICD-10, the Provider Perspective.

Announcements

- CMS Updates EFT Authorization Agreement: CMS 588.
- Physician Compare: 2012 GPRO Measures Preview Period.
- Password Reset in the I&A System.
- New QIO Program RFPs Posted.
- Ordering and Referring Denial Edits Will Be Implemented on January 6.
- New Proposed EHR Meaningful Use Timeline.
- Important EHR Payment Adjustment Information for Medicare EPs.
- EHR Incentive Programs: Learn How to Conduct a Security Risk Analysis for Your Practice.

MLN Educational Products

- Winter 2013 Version of Medicare Learning Network Catalog Now Available.
- "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius" MLN Matters® Article – Released.
- "Further Details on the Revalidation of Provider Enrollment Information" MLN Matters® Article – Revised.
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet – Revised.
- "The DMEPOS Competitive Bidding Program: Non-Contract Supplier" Fact Sheet – Revised.
- "Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record" Fact Sheet – Reminder.

- "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet – Reminder.

December 19, 2013: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-19-Enews.pdf

MLN Connects™ National Provider Calls

- 2-Midnight Benchmark for Inpatient Hospital Admissions – Registration Now Open.
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule – Register Now.
- 2012 Quality and Resource Use Reports Overview and December Addendum – Registration Now Open.
- National Partnership to Improve Dementia Care in Nursing Homes – Registration Now Open.
- Did You Miss This MLN Connects Call?

Announcements

- Remember To Ask, Have You Gotten Your Flu Shot?
- DMEPOS Competitive Bidding Program: January 1, 2014 Round 1 Recompete Implementation – Resources.
- Step-by-Step Instructions for Using the I&A System to Access PECOS, EHR, and NPPES.
- HHS Announces Affordable Care Act Mental Health Services Funding.
- More Than 25 Million Original Medicare Beneficiaries Received Free Preventive Services through November 2013.
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines.
- Upcoming Deadline for EPs in EHR Incentive Programs; Prepare for Attestation.
- Request an Informal Review of 2014 eRx Payment Adjustment.

Claims, Pricers, and Codes

- CMS Furnishes Final List of Off-The-Shelf Orthotic HCPCS Codes.
- MLN Educational Products.
- "Mental Health Services" Booklet – Revised.
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet – Reminder.

MLN Connects™ Provider e-News Special Edition - December 30, 2013

This special edition of the MLN Connects™ Provider e-News includes the following information:

Announcements

Verifying Patient Coverage in a Health Insurance Marketplace Plan

It is the beginning of the New Year and you'll be verifying your patient's insurance status when they show up in your office. With the beginning of the Health Insurance Marketplace, also known as Health Insurance Exchange, over a million people will have a new insurance plan. In many cases, this will be the first time they have had insurance in years. Many of these people will have signed up for their plan within the past few days. They may not have received their card yet or they may be unaware of the need to carry their insurance information. You may find your office needing to verify their coverage.

How do you verify their coverage?

If the marketplace in your state is run by the Federal government, it is best to call their plan's customer service line, a list of all plans and their customer service numbers can be found in this data base. Here's a fact sheet for using the data base. If you can't find the number, call the Marketplace Call Center (1-800-318-2596).

If your state has its own health insurance exchange, contact your state. To find the website for your state exchange, select the name of your state in the box at the left hand side of the healthcare.gov website.

How else can you help your patient?

Remind your patients to keep all of their paperwork and receipts from all of their doctor's appointments and from the pharmacy as well. They may need them for their insurer. Remind them they should carry their card at all times. If they don't have a card, they can contact their plan to get a card.

If the patient is uninsured, they have until March 31st to sign up for non-employer based coverage. They can go to HealthCare.gov to sign up for a plan and apply for financial assistance. The vast majority of uninsured will qualify for financial assistance to reduce their costs. You can also download copies of fact sheets or educational material for your patients.

MLN Connects™ National Provider Calls

2-Midnight Benchmark for Inpatient Hospital Admissions – Register Now

Tuesday, January 14; 1:30-3pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

This MLN Connects Call provides an overview of the inpatient hospital admission and medical review criteria (also known as the 2-Midnight Rule) that was released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System/Long-Term Care Hospital final rule (CMS-1599-F). CMS will present case scenarios on the application of the rule to sample medical records. Following the presentation, CMS will address frequently asked questions received from providers.

Agenda:

- Summary of the 2-Midnight Rule.
- Case example presentation.
- Question and answer session.

Target Audience: Hospitals, physicians and non-physician practitioners, case managers, medical and specialty societies, and other healthcare professionals.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule – Register Now

Wednesday, January 15; 2-3:30pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

On January 15, CMS, Center for Clinical Standards and Quality (CCSQ) will host an MLN Connects™ Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance quality program that ties a facility's performance to a payment reduction over the course of a payment year (PY). This MLN Connects Call will focus on the final rule for operationalizing the ESRD QIP in PY 2016, which was put on display on November 22, 2013.

The performance period for PY 2016 will begin on January 1, 2014. Facilities and other stakeholders should take steps to understand the contours of the program. After the presentation, participants will have an opportunity to ask questions.

Agenda:

- ESRD QIP legislative framework and how it fits in with CMS strategies to improve quality.
- Changes reflected in the final rule based on public comments.
- The final measures, standards, scoring methodology, and payment reduction scale that are applied to the PY 2016 program.
- How the PY 2016 program compares to PY 2015.
- Where to find additional information about the program.
- Question and answer session.

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders and quality improvement experts, and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls.

Visit the Continuing Education Credit Information web page to learn more.

2012 Quality and Resource Use Reports Overview and December Addendum – CE Credit Available – Register Now

Thursday, January 16; 2:30-4pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early. This MLN Connects Call has been approved by CMS for CME and CEU continuing education credit (CE). Review CE Activity Information & Instructions for specific details.

This MLN Connects Call will provide an overview of the 2012 Quality and Resource Use Reports (QRURs), including a review of the December addendum and how to interpret and use the data in the report.

On September 16, CMS released the 2012 QRURs to group practices with 25 or more eligible professionals (EPs). The QRUR previews each group's performance on quality and cost measures that could be used to calculate the group's Value-Based Payment Modifier in 2015. On December 23, CMS released an addendum to the 2012 QRURs to include individual eligible professional (EP) PQRS performance data. The addendum will be available for all group practices with 25 or more EPs for which at least one EP reported PQRS measures as an individual in 2012 and was found to be incentive eligible.

Agenda:

- How to understand and use the QRURs.
- Individual EP PQRS performance data addendum.
- Question and answer session.

Target Audience: Groups with 25 or more eligible professionals.

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

Wednesday, February 26; 2-3:30pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

The CMS National Partnership to Improve Dementia Care in Nursing homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings as well.

During this MLN Connects Call, a CMS subject matter expert will discuss the critical role of both state and federal surveyors in the implementation of the partnership. Additional speakers will be presenting on the importance of leadership, as well as the strong correlation that exists between proper pain assessment and antipsychotic medication use. A question and answer session will follow the presentation.

Agenda:

- Role of surveyors.
- Importance of leadership.
- Proper pain assessment.
- Next steps.

January 16, 2014: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-16-enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- Providers and Suppliers – Browse the MLN Connects™ Call Program Collection of Resources.

MLN Connects™ Videos

- ICD-10 Coding Basics.
- CMS Events.
- Hospice Open Door Forum.

Announcements

- Connections in the I&A System.
- CMS to Release a Comparative Billing Report on PAP Devices and Accessories in January.
- CMS Quality Strategy – Response Period Extended to January 24.
- Review the 2014 PQRS Measures Codes Resources for Claims and Registry-Based Reporting.
- Medicare EPs Must Attest by February 28 to Receive 2013 Incentive for EHR Incentive Program.

Claims, Pricers, and Codes

- Processing Repair Claims for Capped Rental DME Furnished by the Scooter Store Related Suppliers.
- Temporary Hold of Home Health LUPA Claims.
- Quarterly Provider Specific Files for the Prospective Payment System Now Available.
- January 2014 Outpatient Prospective Payment System Pricer File Update.

MLN Educational Products

- "Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-to-Face Encounter".

MLN Matters® Article – Released

- MLN Products Now Available in Hard Copy Format.
- Medicare Learning Network® Pilot Testers and Product Reviewers Needed.
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists.

January 23, 2014: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-23-enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- Need to Learn More About ICD-10? The MLN Connects™ Collection of Resources Can Help.

CMS Events

- Comparative Billing Report Teleconference.

Announcements

- Continue Seasonal Flu Vaccination through January and Beyond.
- Submit Quality Data for 2013 PQRS-Medicare EHR Incentive Pilot by February 28.

Claims, Pricers, and Codes

- Revised CMS 1500 Paper Claim Form: Version 02/12.

MLN Educational Products

- "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet – Revised.

January 30, 2014: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-30eNews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- Previous MLN Connects™ Calls on the National Partnership to Improve Dementia Care in Nursing Homes.
- Did You Miss These MLN Connects™ Calls?

CMS Events

- Special Open Door Forum: Final Rule CMS-1599-F.
- Hospice Item Set Manual and Data Collection Training Slides Now Available.

Announcements

- QCDR Self-Nominations for 2014 PQRS Program Year Accepted Through January 31.
- 2014 is the Last Year EPs Can Earn a PQRS Incentive Payment.

MLN Educational Products

- "Probe & Educate Medical Review Strategy: Probe Reviews of Inpatient Hospital Claims and Corresponding Provider Outreach and Education" MLN Matters® Article – Released.
- "Registration of Entities Using the Indirect Payment Procedure (IPP)" MLN Matters® Article – Released.
- "Mass Immunizers and Roster Billing" Fact Sheet – Revised.
- New MLN Provider Compliance Fast Fact.
- MLN Products Available in Electronic Publication Format.

February 6, 2014: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-06-Enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification – Registration Opening Soon.

CMS Events

- eHealth Summit: Road to ICD-10.
- Physician Compare Town Hall Meeting.
- Webinar for Comparative Billing Report on Upper Limb Orthotics.

Announcements

- Medicare Heart Healthy Preventive Services.
- Flu Activity is Widespread – Continue to Recommend and Offer Flu Vaccination.
- Medicare's Delivery System Reform Initiatives Achieve Significant Savings and Quality Improvements – Off to a Strong Start.
- HHS Strengthens Patients' Right to Access Lab Test Reports.
- NPPES Modernization – We Need Your Feedback.
- New Feature: Simple Online Reset of User IDs and Passwords for PECOS, NPPES, and EHR.
- 2013 was Final Program Year for Medicare eRx Incentive Program.
- CMS to Release a Comparative Billing Report on Upper Limb Orthotics in February.
- Submit Quality Data for 2013 PQRS-Medicare EHR Incentive Pilot by February 28.
- Learn What's New in 2014 for PQRS Participation.
- New EHR Data Brief Takes a Closer Look at EHR Participation.
- EHR Incentive Program: Important Payment Adjustment Information for Medicare EPs.

Claims, Pricers, and Codes

- Notification Regarding the New Benefits Coordination & Recovery Center.
- Claims Hold for ESRD Facilities that Waived Full PPS Payment.
- HIPAA 837 Institutional COB Claims Not Crossing Over Due to Error H24391.

MLN Educational Products

- "Psychiatry and Psychotherapy Services" MLN Matters® Article – Released.
- "Guidance on Hospital Inpatient Admission Decisions" Podcast – Released.
- "Post-Acute Care Transfer – Underpayments" Podcast – Released.
- The "Diagnosis Coding: Using the ICD-9-CM" Web-Based Training Course – Revised.
- "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" Booklet – Revised.
- Updated MLN Matters® Search Indices.
- MLN Product Available in Electronic Publication Format.
- New MLN Educational Web Guides Fast Fact.

February 13, 2014: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-13Enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification – Registration Now Open.

CMS Events

- Physician Compare Town Hall Meeting.

Announcements

- Increasing Transparency in Health Care with Open Payments.
- Teaching Hospital Closures: Rounds 4 and 5 of Section 5506 of the Affordable Care Act.
- Extension of Expiring Passwords in the I&A System.
- Next PEPPER Release for SNFs, Hospices, LTCHs, Free-Standing IPFs, IRFs, and PHPs to be Available Electronically.
- Submit Suggestions for Advanced Diagnostic Imaging Program.
- Help Your Patients Navigate the Health Insurance Marketplace.
- New EHR Attestation Deadline for Eligible Professionals: March 31.
- EHR Incentive Programs: New CMS and ONC Tool Enables Providers to Meet Transitions of Care Measure.
- ICD-10 in 2014.

Claims, Pricers, and Codes

- Hold for Hospice Claims Containing a Service Facility NPI.
- Reprocessing of Air Ambulance Claims.
- CY 2014 HH PPS Mainframe Pricer Software Now Available.

MLN Educational Products

- Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492" MLN Matters® Article – Released.

- "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article – Revised.
- "Critical Access Hospital" Fact Sheet – Revised.
- Order and Download the Latest MLN Educational Products from the MLN Product Ordering System.
- "Guidance on Hospital Inpatient Admission Decisions" Podcast – Rescinded.

View the complete issue of the MLN Connects™ Provider eNews for February 20, 2014.

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Last Chance to Register.
- 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification – Last Chance to Register.

Announcements

- Flu Activity is Widespread – Continue to Recommend and Offer Flu Vaccination.
- CMS to Release a Comparative Billing Report on Nebulizer Drugs in March.
- Use New PQRS Interactive Timeline to Prepare for Upcoming Milestones.
- Claims, Pricers, and Codes.
- Hospitals Should Hold Certain A/B Rebilling Outpatient Claims.

MLN Educational Products

- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article – Released.
- "HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" MLN Matters® Article – Revised.
- "Hospice Payment System" Fact Sheet – Revised.
- "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet – Revised.
- "Sole Community Hospital" Fact Sheet – Revised.
- Updated MLN Matters® Search Indices.

View the complete issue of the MLN Connects™ Provider eNews for February 27, 2014.

MLN Connects™ National Provider Calls

- PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 – Registration Opening Soon.
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run – Registration Opening Soon.

CMS Events

- Register for ICD-10 Testing Week: March 3–7.
- ICD-10 Coordination and Maintenance Committee Meeting.
- Webinar for Comparative Billing Report on Nebulizer Drugs.

Announcements

- Quality Data Added to Physician Compare Website.
- Next Edition of Electronic Health Record Technology Certification Criteria Issued.
- Adult Immunization: Are You Meeting the Standards for Patient Care?
- Open Payments: Additional Phase 1 Registration and Data Submission Resources Now Available.
- Important Information about Upcoming HQRP Reporting Cycle Deadlines.

- Deadline for Physician-owned Hospitals to Report Ownership and Investment Information Extended to March 1.
- Submit Suggestions for Advanced Diagnostic Imaging Program.
- 2013 Final Program Year for the Medicare eRx Incentive Program.
- Prepare for Upcoming eHealth Milestones with New eHealth Interactive Timeline.
- New and Updated FAQs for the EHR Incentive Programs Now Available.

Claims, Pricers, and Codes

- FY 2014 Inpatient PPS PC Pricer Updated with New Provider Data.

MLN Educational Products

- "Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014" MLN Matters® Article – Released.
- "Basic Medicare Information for Providers and Suppliers" Guide – Revised.
- "Medicare Disproportionate Share Hospital" Fact Sheet – Revised.
- "Acute Care and the IPPS" Web-Based Training Course – Revised.
- New MLN Educational Web Guides Fast Fact.
- New MLN Provider Compliance Fast Fact.

View the complete issue of the MLN Connects™ Provider eNews for March 6, 2014.

MLN Connects™ National Provider Calls

- PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 – Registration Now Open.
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run – Registration Now Open.

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting.

Announcements

- Help Your Medicare Patients "Enjoy the Taste of Eating Right" During National Nutrition Month® and Beyond.
- The Flu Season Is Not Over: It's Not Too Late to Get a Flu Vaccine.
- HQRP Deadline: FY 2015 Reporting Cycle Data due April 1.
- ICD-10 eHealth University Resources.

Claims, Pricers, and Codes

- April 2014 Average Sales Price Files Now Available.

MLN Educational Products

- "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies" MLN Matters® Article – Released.
- 2014 Medicare Part C and Part D Reporting Requirements for Data Validation WBT – Released.
- "Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014" MLN Matters® Article – Revised.
- "The DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet – Revised.
- "The DMEPOS Competitive Bidding Program: Hospitals That Are Not Contract Suppliers" Fact Sheet – Revised.
- "Ambulance Fee Schedule" Fact Sheet – Revised.
- "End-Stage Renal Disease Prospective Payment System" Fact Sheet – Revised.

- "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet – Revised.
- "Quick Reference Information: Home Health Services" Educational Tool – Revised.
- "Quick Reference Information: Preventive Services" Educational Tool – Revised.

COMPETITIVE BIDDING

Quarterly Update for DMEPOS Competitive Bidding Program – April 2014

MLN Matters® Number: MM8568
Related Change Request (CR) #: CR 8568
Related CR Release Date: January 10, 2014
Related CR Transmittal #: R2853CP
Effective Date: April 1, 2014
Implementation: April 7, 2014

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.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8568 to provide the DMEPOS CBP April 2014 quarterly update. CR 8568 provides specific instructions for 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. 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 expires on December 31, 2013. On January 1, 2014, new contracts for the Round One Recompete in the same nine areas take effect. There will also be some changes to the specific DMEPOS items that are part of the program in these areas starting on January 1, 2014.

Additional Information

The official instruction, CR 8568, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2853CP.pdf on the CMS website.

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 about the CBP is also available at http://www.dmecompetitivebid.com on the Internet. The information at this site includes information on all rounds of the CBP including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

Payment Rules – Continuous Passive Motion Machines

DME MAC Joint Publication – Revised

Medicare covers continuous passive motion devices (CPM) under the Durable Medical Equipment Benefit. Reasonable and Necessary (R&N) requirements are set out in CMS National Coverage Determination 280.1. The NCD states:

> *Continuous passive motion devices are devices Covered (sic) for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.*

Note that CMS has clarified to the DME MACs that in addition to a total knee replacement, a CPM device is also covered following the revision of a major component of a previous total knee replacement (i.e., tibial components or femoral component).

Additional billing instructions are provided in CMS Claim Processing Manual (Internet-only Publication 100-04) Chapter 20 Section 30.2.1 which states:

Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period.

Coding Guidelines

Continuous Passive Motion devices are classified under two HCPCS codes:

- E0935 – CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY
- E0936 – CONTINOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE

Recent questions regarding the exact nature of these devices reveal confusion regarding the nature and functionality of these devices. These coding guidelines clarify the types of products described by the CPM codes.

The first test of any durable medical equipment is that it be durable and capable of repeated use over the expected five-year useful life expectancy. Elastic, fabric, single use, or light plastic devices are not durable and do not meet the test for DME.

Secondly, the equipment must be capable of continuous passive motion of the affected limb. These characteristics mean that the device must have inherent within itself the ability to move the affected limb:

- In an appropriate plane of motion.
- In a continuous fashion.
- At the same rate of speed.

- For a prescribed length of time.
- With adjustable limits of range of motion.
- With an identical range of motion in each cycle.
- Without any input from the patient by the contralateral or other limbs.
- With easily accessible safety or cutoff switches.

These characteristics require that the device be electrically powered, either by AC current or battery. Battery powered models must have an AC adapter for long term use. CPM machines must meet all these characteristics in order to be coded as E0935 or E0936.

Patient-controlled stretch devices are not considered CPM devices and must not be billed using codes E0935 or E0936. These devices are considered exercise equipment and are coded A9300.

Coverage and Documentation

Based upon the NCD, Continuous passive range of motion devices (CPM) are covered by Medicare only if all of the following are met:

- CPM treatment is started after a total knee replacement or a revision of a major component of a previously performed total knee replacement. CPMs are not covered after any other type of knee or joint surgery.
- CPM treatment must be applied within 48 hours of surgery to be eligible for Medicare coverage.

Claims for items that do not meet these criteria will be denied as not reasonable and necessary.

Coverage is limited to 21 days from the date of surgery. The DME MAC should be billed only for those days of CPM treatment after discharge from the hospital.

The supplier must have a detailed written order signed and dated by the ordering physician in their file prior to submitting a claim for a CPM.

In the event of an audit there must be information in the medical record showing that the coverage criteria are met.

When billing for a CPM (HCPCS code E0935), all of the following documentation must be included with the claim:

- Type of knee surgery performed.
- Date of surgery.
- Date of application of CPM.
- Date of discharge from the hospital.

Claims submitted without this required information will be denied as not reasonable and necessary.

Refer to the Supplier manual for additional information about coverage, coding and documentation requirements.

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

Clarification of Face-to-Face Encounter Requirements for Certain DME

On December 3, 2013, the Centers for Medicare & Medicaid Services (CMS) published an announcement regarding the delay in enforcement of the face-to-face requirements established by Section 6407 of the Affordable Care Act. This announcement clarified that the enforcement delay only applies to the new DME face-to-face requirements. While active enforcement of the face-to-face requirements has been postponed until a future date to be announced in Calendar Year 2014, the delay does not impact provisions related to written orders prior to delivery. Noridian will begin enforcement of the written order prior to delivery requirement for dates of service (DOS) on or after January 1, 2014.

Accordingly, as of July 1, 2013, the DME items on the Specified Covered Items list require that the supplier obtain a detailed written order prior to delivery. All written orders shall follow the guidance in the CMS Program Integrity Manual (Internet-only manual, Publication. 100-08), Chapter 5, Section 5.2.3, and shall include, at a minimum, the following elements listed in the regulation:

1. The beneficiary's name.
2. The DME item ordered.
3. The prescribing practitioner's National Provider Identification (NPI).
4. The signature of the prescribing practitioner.
5. The date of the order.

The requirements listed in the regulation do not supersede other CMS requirements for detailed written orders. Per the standard documentation guidelines, detailed written orders must also include the following:

1. Physician's Name.
2. Start date of the order (if different from the date of the order).
3. Signature date personally entered by the ordering practitioner.
4. Dosage or concentration, if applicable.
5. Route of administration, if applicable.
6. Frequency of use.
7. Duration of infusion, if applicable.
8. Quantity to be dispensed.
9. Number of refills, if applicable.

Failure to obtain a valid detailed written order prior to delivery will result in the item being denied as excluded by statute.

For additional information concerning the face-to-face encounter requirements and a list of DMw items on the Specified Covered List, please refer to the CMS Medicare Learning Network article, "MM8304 – Detailed Written Orders and Face-to-Face Encounters".

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

DME MAC Joint Publication

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

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

- For all claims for purchases or initial rentals.
- When there is a change in the prescription for the accessory, supply, drug, etc.

- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis).
- When an item is replaced.
- When there is a change in the supplier.
- When required by state law.

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

These Affordable Care Act requirements are effective for claims for all of the specified items that require a new order (prescription) on or after July 1, 2013. Enforcement of these rules related to the face-to-face examination requirement and face-to-face documentation is delayed until a date to be announced by CMS in Calendar Year 2014. This delay in enforcement does not apply to the prescription requirements for a Written Order Prior to Delivery or to the requirement to include the prescriber's NPI on the prescription.

ACA 6407 also contains provisions requiring that a physician verify that a face-to-face examination performed by a PA, NP or CNS was done within the 6 months prior to the creation of a prescription for the specified item(s). This article does not address these provisions in detail. Additional information addressing physician verification will be forthcoming.

Face-To-Face Examination Requirements

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

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

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

For the physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.
- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.
- The prescriber must provide a copy of the face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item can be delivered.

Prescription (order) Requirements

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

- Beneficiary's name.
- Physician's Name.
- Date of the order and the start date, if start date is different from the date of the order.

- Detailed description of the item.
- The prescribing practitioner's National Provider Identifier (NPI).
- The signature of the ordering practitioner.
- Signature date.

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

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

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

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

Date and Timing Requirements

There are specific date and timing requirements:

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

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

Claim Denial

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

Local Coverage Determinations (LCD)

LCDs that contain items subject to these requirements are:

- Automatic External Defibrillators.

- Cervical Traction Devices.
- External Infusion Pumps.
- High-frequency Chest Wall Oscillation Devices.
- Home Glucose Monitors.
- Hospital Beds.
- Manual In-exsufflation Devices.
- Manual Wheelchairs.
- Nebulizers.
- Osteogenesis Stimulators.
- Oxygen.
- Patient Lifts.
- Pneumatic Compression Devices.
- Positive Airway Pressure Devices.
- Power Mobility Devices.
- Pressure Reducing Support Surfaces – Group 1.
- Pressure Reducing Support Surfaces – Group 3.
- Respiratory Assist Devices.
- Seat Lift Mechanisms.
- Speech Generating Devices.
- Transcutaneous Electrical Nerve Stimulators (TENS).
- Wheelchair options and Accessories.
- Wheelchair Seating.

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

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

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

Table A: DME List of Specified Covered Items

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

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

HCPCS Code	Description
E0185	Gel or gel-like pressure mattress pad
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad
E0194	Air fluidized bed

HCPCS Code	Description
E0197	Air pressure pad for mattress standard length and width
E0198	Water pressure pad for mattress standard length and width
E0199	Dry pressure pad for mattress standard length and width
E0250	Hospital bed fixed height with any type of side rails, mattress
E0251	Hospital bed fixed height with any type side rails without mattress
E0255	Hospital bed variable height with any type side rails with mattress
E0256	Hospital bed variable height with any type side rails without mattress
E0260	Hospital bed semi-electric (Head and foot adjustment) with any type side rails with mattress
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress
E0265	Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress
E0266	Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress
E0290	Hospital bed fixed height without rails with mattress
E0291	Hospital bed fixed height without rail without mattress
E0292	Hospital bed variable height without rail without mattress
E0293	Hospital bed variable height without rail with mattress
E0294	Hospital bed semi-electric (head and foot adjustment) without rail with mattress
E0295	Hospital bed semi-electric (head and foot adjustment) without rail without mattress
E0296	Hospital bed total electric (head, foot and height adjustments) without rail with mattress
E0297	Hospital bed total electric (head, foot and height adjustments) without rail without mattress
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, without mattress
E0302	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress
E0303	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, with mattress
E0304	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, with mattress
E0424	Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing

HCPCS Code	Description
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (1 months supply)
E0442	Oxygen contents, liquid (1 months supply)
E0443	Portable Oxygen contents, gas (1 months supply)
E0444	Portable oxygen contents, liquid (1 months supply)
E0450	Volume control ventilator without pressure support used with invasive interface
E0457	Chest shell
E0459	Chest wrap
E0460	Negative pressure ventilator portable or stationary
E0461	Volume control ventilator without pressure support node for a noninvasive interface
E0462	Rocking bed with or without side rail
E0463	Pressure support ventilator with volume control mode used for invasive surfaces
E0464	Pressure support vent with volume control mode used for noninvasive surfaces
E0470	Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface
E0471	Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface
E0480	Percussor electric/pneumatic home model
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High Frequency chest wall oscillation air pulse generator system
E0484	Oscillatory positive expiratory device, non-electric
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic, large volume
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter
E0585	Nebulizer with compressor & heater
E0601	Continuous airway pressure device
E0607	Home blood glucose monitor
E0627	Seat lift mechanism incorporated lift-chair
E0628	Separate Seat lift mechanism for patient owned furniture electric
E0629	Separate seat lift mechanism for patient owned furniture non-electric
E0636	Multi positional patient support system, with integrated lift, patient accessible controls
E0650	Pneumatic compressor non-segmental home model
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0655	Non- segmental pneumatic appliance for use with pneumatic compressor on half arm
E0656	Non- segmental pneumatic appliance for use with pneumatic compressor on trunk

HCPCS Code	Description
E0657	Non- segmental pneumatic appliance for use with pneumatic compressor chest
E0660	Non- segmental pneumatic appliance for use with pneumatic compressor on full leg
E0665	Non- segmental pneumatic appliance for use with pneumatic compressor on full arm
E0666	Non- segmental pneumatic appliance for use with pneumatic compressor on half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full-leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg
E0671	Segmental gradient pressure pneumatic appliance full leg
E0672	Segmental gradient pressure pneumatic appliance full arm
E0673	Segmental gradient pressure pneumatic appliance half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel treatment 4 foot panel
E0693	Ultraviolet light therapy system panel treatment 6 foot panel
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0840	Tract frame attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame

HCPCS Code	Description
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958**	Manual wheelchair accessory, one-arm drive attachment
E0959**	Manual wheelchair accessory-adapter for Amputee
E0960**	Manual wheelchair accessory, shoulder harness/strap
E0961**	Manual wheelchair accessory wheel lock brake extension handle
E0966**	Manual wheelchair accessory, headrest extension
E0967**	Manual wheelchair accessory, hand rim with projections
E0968*	Commode seat, wheelchair
E0969*	Narrowing device wheelchair
E0971**	Manual wheelchair accessory anti-tipping device
E0973**	Manual wheelchair accessory, adjustable height, detachable armrest
E0974**	Manual wheelchair accessory anti-rollback device
E0978*	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap
E0980*	Manual wheelchair accessory safety vest
E0981**	Manual wheelchair accessory Seat upholstery, replacement only
E0982**	Manual wheelchair accessory, back upholstery, replacement only
E0983**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control
E0984**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986**	Manual wheelchair accessory, push activated power assist
E0990**	Manual wheelchair accessory, elevating leg rest
E0992**	Manual wheelchair accessory, elevating leg rest solid seat insert
E0994*	Arm rest
E1014	Reclining back, addition to pediatric size wheelchair
E1015	Shock absorber for manual wheelchair
E1020	Residual limb support system for wheelchair
E1028**	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029**	Wheelchair accessory, ventilator tray
E1030**	Wheelchair accessory, ventilator tray, gimbaled
E1031	Rollabout chair, any and all types with castors 5" or greater
E1035**	Multi-positional patient transfer system with integrated seat operated by care giver
E1036**	Patient transfer system
E1037	Transport chair, pediatric size
E1038**	Transport chair, adult size up to 300lb
E1039**	Transport chair, adult size heavy duty >300lb
E1161	Manual Adult size wheelchair includes tilt in space

HCPCS Code	Description
E1227*	Special height arm for wheelchair
E1228*	Special back height for wheelchair
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233**	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1296*	Special sized wheelchair seat height
E1297*	Special sized wheelchair seat depth by upholstery
E1298*	Special sized wheelchair seat depth and/or width by construction
E1310**	Whirlpool non-portable
E2502**	Speech Generating Devices prerecord messages between 8 and 20 Minutes
E2506**	Speech Generating Devices prerecord messages over 40 minutes
E2508**	Speech Generating Devices message through spelling, manual type
E2510**	Speech Generating Devices synthesized with multiple message methods
E2227**	Rigid pediatric wheelchair adjustable
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength ltwt wheelchair
K0005	Ultra Lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base
K0606**	AED garment with electronic analysis
K0730	Controlled dose inhalation drug delivery system

Medicare System Project for Electronic Submission of Medical Documentation (esMD)

MLN Matters® Number: SE1343

Provider Types Affected

This Special Edition (SE) MLN Matters® Article is intended for all Medicare Fee-For-Service (FFS) providers and suppliers who submit medical documentation to Medicare review contractors.

Provider Action Needed

This article is based on the utilization of the Electronic Submission of Medical Documentation (esMD) via Medicare's esMD Gateway to respond to review contractor's requests for medical documentation.

Background

The Centers for Medicare & Medicaid Services (CMS) uses several types of review contractors to measure, prevent, identify, and correct improper payments or identify potential fraud.

Review contractors find improper payments and potential fraud by reviewing a sample of claims. They request medical documentation from the provider or supplier and manually review the claims against the medical documentation to verify the providers' compliance with Medicare's rules.

As of September 2011, providers are able to respond to these requests for medical documentation electronically using the Electronic Submission of Medical Documentation (esMD) via Medicare's esMD Gateway. Since September 2011, CMS enhanced the esMD Gateway to support several new use cases, for example:

- In September 2012, CMS implemented a Prior Authorization (PA) process via the esMD Gateway for Power Mobility Devices (PMD) for FFS Medicare beneficiaries who reside in seven states with high populations of error prone providers (CA, IL, MI, NY, NC, FL and TX).
- In January 2013, CMS expanded the CMS esMD Gateway to allow Durable Medical Equipment (DME) suppliers and providers to send electronic PA Requests to Medicare review contractors.
- In June 2013, CMS enabled automated Prior Authorization Review Results Responses from Medicare review contractors to Health Information Handlers (HIHs) via the esMD Gateway.

Medicare's esMD system provides an alternative mechanism for submitting medical documentation, PMD PA requests, and PMD result code responses to review contractors. A list of review contractors that will accept esMD transactions, as well as receive PMD PA requests and send PMD PA review results can be found at http://go.cms.gov/RevCon on the CMS website.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing paper processing and mailing of medical documentation to review contractors.

The number of participants in the CMS esMD Program has grown steadily since its inception.

As of September 30, 2013:

- 449,460 Unique Medical Record Transactions have been submitted.
- 30,199 Medicare Providers are using esMD to respond to medical record requests.
- 55 Medicare Providers use esMD to submit Prior Authorization Requests.
- 24 HIHs are certified by CMS to offer esMD services.
- 27 Review Contractors are approved by CMS to accept medical records via esMD.

Medicare providers, including physicians, hospitals, and suppliers must obtain access to a CONNECT-compatible gateway in order to send medical documentation electronically to review contractors.

For example:

- Larger providers, such as hospital chains, may choose to build their own gateway.
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a HIH that offers esMD Gateway services.

HIHs contract with providers to supply them with esMD services much the same way that providers contract with claims clearinghouses to supply them with claims submission services.

A listing of the HIHs that have been approved by CMS to offer esMD services can be found at http://go.cms.gov/esmd-HIH on the CMS website.

HIH's set the price of their esMD provider services. Providers are encouraged to contact one or more of the HIHs to determine what esMD services are available.

While esMD is not mandatory, many healthcare providers find that it reduces costs,increases efficiency, and shortens processing times for certain transactions. CMS has instructed review contractors to not target providers for medical review based on their use of esMD.

The esMD system accepts Portable Document Format (PDF) files, which enables providers to use esMD services as long as they have the proper scanning mechanism. Some HIHs may offer scanning services in addition to their esMD services.

DOCUMENTATION

Additional Information

If you have any questions, please contact the review contractor to whom you wish to send esMD transactions. The review contractor toll-free numbers can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

For more information, visit the esMD webpage at http://www.cms.gov/esmd on the CMS website, or follow esMD on Twitter @CMSGov (#CMS_esMD).

For more information on the Medicare Recovery Audit program, see the MLN Matters® article SE1024 at http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf on the CMS website.

Contact information for your Recovery Auditor is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RAC-Contact-Information-AbbrState-Apr2013.pdf on the CMS website.

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

DRUGS & BIOLOGICALS

Aprepitant for Chemotherapy Induced Emesis

MLN Matters® Number: MM8418
Related Change Request (CR) #: CR 8418
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R180BP, R2883CP, and R163NCD
Effective Date: May 29, 2013
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Part A Medicare Administrative Contractors (A/MACs) and/or Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8418, which informs MACs that, effective for claims with dates of service on or after May 29, 2013 , the Centers for Medicare & Medicaid Services (CMS) extends coverage of the oral antiemetic three-drug regimen of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone to beneficiaries who are receiving certain anticancer chemotherapeutic agents. Make sure that your billing personnel are aware of these changes.

Background

Chemotherapy induced emesis is the occurrence of nausea and vomiting during or after anticancer treatment with chemotherapy agents. The Social Security Act (the Act) permits oral drugs to be paid under Part B in very limited circumstances, one of which is antiemetic therapy administered immediately before and within 48 hours after anticancer chemotherapy as described in section1861(s)(2) of the Act. These drugs must fully replace the non-self-administered drug that would otherwise be covered.

On April 4, 2005, CMS announced a National Coverage Determination (NCD) for the use of the oral three-drug regimen of aprepitant, a 5HT3 antagonist, and dexamethasone for patients who are receiving certain highly emetogenic chemotherapeutic agents.

On May 29, 2013, CMS announced an update to that NCD, to cover the use of the oral antiemetic three-drug combination of oral aprepitant (J8501), an oral 5HT3 antagonist (Q0166, Q0179, Q0180), and oral dexamethasone (J8540) for patients receiving highly and moderately emetogenic chemotherapy. As a result, effective for services on or after May 29, 2013, the following anticancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab (J9010)
- Azacitidine (J9025)
- Bendamustine (J9033)
- Carboplatin (J9045)
- Clofarabine (J9027)
- Cytarabine (J9098, J9100, J9110)
- Daunorubicin (J9150, J9151)
- Idarubicin (J9211)
- Ifosfamide (J9208)
- Irinotecan (J9206)
- Oxaliplatin (J9263)

Please note the entire list includes the 11 new codes listed above and the 9 existing anticancer chemotherapeutic agents listed below:

- Carmustine (J9050)
- Cisplatin (J9060, J9062)
- Cyclophosphamide (J8530, J9070, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, J9097
- Dacarbazine (J9130, J9140)
- Mechlorethamine (J9230)
- Streptozocin (J9320)
- Doxorubicin (J9000, J9001, J9002, Q2048, Q2049)
- Epirubicin (J9178)
- Lomustine (S0178)

CMS also permits the MACs to determine coverage for other all-oral three-drug antiemesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in combination with an oral 5HT3 antagonist and oral dexamethasone with the chemotherapeutic agents listed, or any other anticancer chemotherapeutic agents that are FDA-approved and may in the future be defined as highly or moderately emetogenic.

CMS is defining highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC). The inclusive examples are: NCCN plus ASCO, NCCN plus ESMO/MASCC, or ASCO plus ESMO/MASCC.

Until a specific code is assigned to the new drug, any new FDA-approved oral antiemesis drug (oral NK-1 antagonist or oral 5HT3 antagonist) as part of the three-drug regimen must be billed with the following not-otherwise-classified (NOC) code effective April 1, 2014, in the IOCE update:

- Q0181 – Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

This NOC code must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (ICD9/10 codes V58.11/Z51.11).

This coverage policy applies only to the oral forms of the three-drug regimen as a full replacement for their intravenous equivalents. All other indications or combinations for the use of oral aprepitant are non-covered under Medicare Part B, but may be considered under Medicare Part D.

For claims with dates of service on or after May 29, 2013, MACs will adjust claims processed before CR8418 was implemented if you bring those claims to the attention of your MAC.

Effective for claims with dates of service on or after May 29, 2013, MACS will deny lines for oral aprepitant (J8501), or NOC code Q0181 if an encounter for antineoplastic chemotherapy identified by ICD 9/10 codes V58.11/Z51.11 is not present. The denied lines will reflect the following messages on the remittance advice:

Claim Adjustment Reason Code 96: Non-covered Charge(s)

Remittance Advice Remarks Code (RARC) M100: We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy; and

RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Additional Information

The official instruction, CR8418, was issued to your MAC via three transmittals. The first updates the "Medicare Benefit Policy Manual" and that is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R180BP.pdf on the CMS website. The second updates the "Medicare Claims Processing Manual" and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2883CP.pdf and the third updates the "Medicare National Coverage Determinations Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R163NCD.pdf on the CMS website.

ASP Quarterly Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – April 2014

MLN Matters® Number: MM8607
Related Change Request (CR) #: CR 8607
Related CR Release Date: January 24, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2863CP
Implementation Date: April 7, 2014

Provider Types Affected

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

Provider Action Needed

Medicare will use the April 2014 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 1, 2014, with dates of services from April 1, 2014, through June 30, 2014.

Change Request (CR) 8607, from which this article is taken, instructs Medicare contractors to implement the April 2014 ASP Medicare Part B drug pricing file for Medicate Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2014, October 2013, July 2013, and April 2013 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the Medicare Claims Processing Manual, Chapter 4, section 50 Outpatient PRICER.

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

Files	Effective for Dates of Service
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, 3014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013

Additional Information

The official instruction, CR 8607, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2863CP.pdf on the CMS website.

Quarterly Results of Widespread Prepayment Review of Claims for Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7507, J7517, J7518 and J7520. The quarterly edit effectiveness results from September 2013 through December 2013 are as follows:

- The J7507 review involved 3,568 claims, of which 2,741 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.
- The J7517 review involved 2,194 claims, of which 1,662 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.
- The J7518 review involved 2,036 claims, of which 1,504 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 70%.
- The J7520 review involved 370 claims, of which 291 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.

Primary Documentation Errors that Resulted in Denial of Claims

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. The supplier standards can be found in 424 CFR Section 424.57(c).

There was no refill request submitted or the refill request submitted was invalid.

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 proof of delivery submitted was invalid.

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:

1. Beneficiary's name.
2. Delivery address.

3. Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description).
4. Quantity delivered.
5. Date delivered.
6. 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:

1. Beneficiary's name.
2. Delivery address.
3. 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.
4. Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description).
5. Quantity delivered.
6. Date delivered.
7. Evidence of delivery.
8. 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 order submitted.

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

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:

1. Description of the item.
2. Beneficiary's name.

3. Prescribing Physician's name.
4. Date of the order and the start date, if the start date is different from the date of the order.
5. 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.

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.

Going Forward

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

Education Resources

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

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

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
May 7, 2014	ICD-10
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.

Viewing Presentation

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

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

KX Modifier

- Definition and Billing.
- Appeals.
- Glucose Monitors and Testing Supplies.
- Affected Policies.
- Resources.

Mechanical In-exsufflation Devices

- Coverage.
- Coding.
- Diagnosis Codes.
- Modifiers.
- Documentation.
- Resources.

Custom Fabricated Orthoses

- AFO/KAFO.
- Knee Orthoses.
- Spinal Orthoses.
- Documentation.

Gastric Suction Pumps

- Benefit Category.
- Capped Rental.
- Capped Rental Modifiers.
- Supplies.
- EY Modifier.
- Documentation.
- Resources.

Review Letters

- Noridian Reviews.
    - Routine Review.
    - Complex Medical Review.
- CERT Reviews.
- Recovery Auditor Reviews.
- Supplemental Study Reviews.
- Final Review.
- Resources.

Remittance Advice

- What is a Remittance Advice.
- Samples.
- Glossary.
- Claim Denials.
- Managing Remittance Advice.
- Resources.

Recovery Auditor: Appeal Options

- Discussion Period.
- Rebuttal.

- Redetermination.
- Recovery Auditor Timeliness.
- Resources.

Negative Pressure Wound Therapy: Documentation

- Intake and Assessment.
- Written Order Prior to Delivery.
- Medical Records.
- Wound Evaluation and Treatment.
- Proof of Delivery.
- Refill Requirements.

Negative Pressure Wound Therapy: Coverage Criteria

- Definitions.
- Initial Coverage.
- In Home Setting Program.
- Inpatient Setting.
- Continued Coverage.
- Coverage Ending.
- Noncovered Information.

PECOS (Provider Enrollment, Chain and Ownership System)

- Implementation.
- Authorized to Order.
- Claim Submission.
- Common Errors.
- Prevention and Resolution.
- Resubmission vs. Appeals.
- Resources.

Intermittent Catheter Kits (A4353): Coding

- Intermittent Urinary Catheter Kits.
- A4353 – Option 1.
- A4353 – Option 2.
- A4353 – Option 3.
- Resources.

Ostomy Supplies

- Coverage Criteria.
- Noncovered Information.
- Continent Stomas.
- Urinary Ostomy.
- Ostomy Irrigation Sets and Clamps.
- Liquid Barriers.

- Faceplate Systems.
- Billing.
- Quantity of Supplies.
- Documentation.
- Resources.

MLN Products

CMS Website.

MLN Matters Articles.

Web-Based Training Courses.

MLN Connects National Provider Calls.

MLN Connects Provider eNews.

Resources

Gradient Compression Stockings

- Coverage Criteria.
- Coding.
- Multi-Layer Systems.
- Modifiers.
- Documentation.
- Orders.
- Resources.

Immunosuppressive Drugs

- Criteria 1: Prescribed.
- Criteria 2: Transplant.
- Criteria 3: Medicare Part A.
- Criteria 4: Medicare Part B.
- Criteria 5: Following discharge after transplant.
- Resources.

Refractive Lenses: Coverage

- Coverage Requirements.
- Contact Lenses.
- Medically Necessary Options.
- Noncovered Options.
- Replacement Lenses and Frames.
- Coding Requirements.
- Documentation.
- Resources.

Wound Suction Pumps

- Benefit Category.
- Capped Rental.

- Wound Suction Pump.
- Wound Suction Systems.
- Dressing Sets.
- Disposable Wound Suction Pumps.
- Modifiers.
- Documentation.
- Resources and Reminders.

Concurrent Use of Oxygen and PAP

- Simultaneous Coverage Consideration.
- Oxygen Testing.
- OSA.
- Oxygen LCD and Policy Article Information.
- PAP LCD and Policy Article Information.
- Resources.

Competitive Bid: Round 1 vs. Round 2

- Determining Residence.
- CBIC Website.
- Round 1 Rebid.
- Round 1 Rebid Product Categories.
- Round 2 and National Mail Order.
- Round 2 Product Categories.
- Round 1 Recompete.
- Round 1 Recompete Product Categories.

Competitive Bid: NMO and Diabetic Supplies

- Competitive Bid.
- Determining Residence.
- CBIC Website.
- National Mail Order.
- NMO Modifier - KL.

Competitive Bid: Determining Residence

- Acronyms.
- Competitive Bid.
- Determining Residence.

Implementation of NACHA Operating Rules for Health Care Electronic Funds Transfers

MLN Matters® Number: MM8629
Related Change Request (CR) #: CR 8629
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1349OTN
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

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 (HH&H MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8629 which informs MACs that they must comply with National Automated Clearinghouse Association (NACHA) Operating Rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH Electronic Funds Transfers (EFT) Network with electronic health care payments. The overarching goal of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a "trace number" that facilitates automatic reassociation of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare.
- Company Name should be the health plan or third party administrator paying the claim.
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05".

- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

The following table explains this example:

Element	Element Name	Mandatory or Optional	Data Content
TRN	Reassociation Trace Number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace Type Code	M	Trace Type Code is always a "1".
TRN02	Reassociation Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

Additional Information

For information on the NACHA Operating Rules that apply to health care payments, particularly with regard to requirements for originators, see https://healthcare.nacha.org/healthcarerules .The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.pdf on the CMS website.

Implementation of HIPAA Standards and Operating Rules for Health Care Electronic Funds Transfers

MLN Matters® Number: MM8619
Related Change Request (CR) #: CR 8619
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R13510TN
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8619, which informs Medicare contractors that Section 1104 of the Affordable Care Act mandates the adoption of a standard for the Health Care Electronic Funds Transfers (EFT) Health Insurance Portability & Accountability Act (HIPAA) transaction and operating rules for the Health Care EFT and Remittance Advice Transaction.

The main intent of these standards and operating rules is to assure health plans transmit a trace number that allows providers to re-associate the EFT health care payment with its associate electronic remittance advice. Make sure that your billing staffs are aware of these changes.

Note that CR 8619 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR8619. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of related CR 8629 (see the related article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8629.pdf can be accommodated by your accounting processes and systems.

Background

The regulation adopting the Health Care EFT standards is available at https://www.federalregister.gov/articles/2012/01/10/2012-132/administrative-simplification-adoption-of-standards-for-health-care-electronic-funds-transfers-efts on the Internet.

The regulation adopting the EFT & ERA Operating Rules can be found at https://www.federalregister.gov/articles/2012/08/10/2012-19557/administrative-simplification-adoption-of-operating-rules-for-health-care-electronic-funds-transfers#h-4 n the Internet.

A new National Automated Clearinghouse Association (NACHA) standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of electronic funds transfers (EFT) used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare.
- Company Name should be the health plan or third party administrator paying the claim.
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05".
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. The TRN data segment must contain the following data elements, separated by an asterisk "*".

Example:

TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

Element	Element Name	Mandatory or Optional	Data Content
TRN	Re-association Trace Number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace Type Code	M	Trace Type Code is always a "1".
TRN02	Re-association Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

Additional Information

The official instruction, CR 8619, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1351OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Revalidation of Provider Enrollment Information – Fifth Revision

MLN Matters® Number: SE1126 Revised

This article was revised on December 9, 2013, to include the 2014 application fee amount of $542.00. All other information remains the same.

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's Contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

In Change Request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register." A related MLN Matters® Article is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website. This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.

All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc – as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855.
- Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC.
- If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do.

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted. Excluded from the revalidation requirements are providers enrolled solely to order and refer items or services to Medicare beneficiaries and practitioners who have opted out of the Medicare program.

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and MACs. Revalidation notices will now be sent through March of 2015.

Important: This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your MAC respond to the request by completing the application either through internet-based PECOS or by completing the appropriate 855 application form.

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

CMS asks all providers who receive a request for revalidation to respond to that request.

- **For providers NOT in PECOS** – the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.
- **For providers in PECOS** – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your MAC. Contact information may be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

CMS will provide the MACs with a list of providers/suppliers requiring revalidation every 60 days beginning October 2013. Within 60 days of receiving the CMS list, MACs will mail the revalidation notices.

Large groups (200+ members) accepting reassigned benefits from providers identified on the CMS list will receive a letter from their MACs informing them that providers linked to their group have been selected to revalidate. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. The letter and spreadsheet will be mailed to the group's correspondence address within 15 days of the MAC receiving the CMS list. This is informational only. Groups should not take any action to revalidate their providers until asked by their MAC to do so.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize Internet-based PECOS or the CMS list available on CMS.gov to determine if their providers have been mailed a revalidation notice.

Note: CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do on the CMS website. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $532.00 for Calendar Year (CY) 2013. The fee for CY 2014 is $542.00. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. **Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.**

A 60-day extension is available if more time is needed to complete the revalidation process. Extension requests should be coordinated with your MAC and requested in writing (fax/email permissible) or via phone. The Individual provider, the Authorized or Delegated Official of the group or the enrollment contact person can request the extension.

A group may request an extension on behalf of individuals reassigned to their group. Group extensions shall also be coordinated through your MACs and must meet the following requirements.

- Only permitted if the provider reassigns all benefits to the group requesting the extension.
- The extension is requested by the Authorized or Delegated Official of the group or the enrollment contact person.
- The Providers' name, National Provider Identifier (NPI) and justification as to why an extension is needed is provided. The extension can be requested in writing (fax/email permissible) or via phone.

Additional Information

To find out whether a provider/supplier has been mailed a revalidation notice go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html on the CMS website.

A sample revalidation letter is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf on the CMS website. A revalidation checklist is available at http://www.cms.gov/Medicare/Provider-http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html on the CMS website.

For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters® Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment web page at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

Implementation of Provider Enrollment Provisions in CMS-6028-FC – Third Revision

MLN Matters® Number: MM7350 Revised
Related Change Request (CR) #: 7350
Related CR Release Date: March 23, 2011
Effective Date: March 25, 2011
Related CR Transmittal #: R371PI
Implementation Date: March 25, 2011

This article was revised on December 9, 2013, to provide the application fee amount of $542.00 for calendar year 2014. All other information remains the same.

Provider Types Affected

All providers and suppliers submitting enrollment applications to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC) are affected by this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register."

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories.
- Submission of application fees as part of the provider enrollment process.
- Suspensions of payment based on credible allegations of fraud.
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

This article is based on Change Request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background

CR7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the "Medicare Program Integrity Manual." Those manual sections are attached to CR7350 and are summarized as follows:

Screening Processes

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the "Program Integrity Manual" (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application Fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS.
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. **Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.**

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for January 1, 2013, through December 31, 2013, is $532.00. The fee for January 1, 2014, through December 31, 2014 is $542.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved.
- An application that was rejected prior to the Medicare Contractor's initiation of the screening process.
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship Exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter **must** accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter **must** accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. **During this review period, the contractor will not begin processing the provider's application.** CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of Hardship Exception Request

As already stated, the application fee for CY 2011 is $505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. **It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship.** The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

- Considerable bad debt expenses.
- Significant amount of charity care/financial assistance furnished to patients, (c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population.
- Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments.
- Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note: The provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. **Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.**

Appeal of the Denial of Hardship Exception Decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the "Program Integrity Manual" (PIM), which is attached to CR7350.

Temporary Moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the Federal Register. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional Information

The official instruction, CR7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R371PI.pdf on the CMS website.

Complete details regarding this issue, as defined in the PIM revisions, are attached to CR7350.

MLN Matters® article SE1126, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf , has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to MLN Matters® article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

A sample letter requesting providers to review, update, and certify their enrollment information is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf on the CMS website.

Billing for Enteral Nutrition

This article clarifies how to determine the correct date of service based on the delivery method, refill requirements, and correct billing for date spans and overlapping dates of service for enteral nutrition.

Delivery Method and Date of Service

If a supplier delivers directly to a beneficiary, the "From" date of service on the claim is the date the item is delivered or picked up in store by the beneficiary or their designee.

If a supplier uses a commercial shipping service (e.g., United States Postal Service, UPS, FedEx) to deliver to a beneficiary, the date the items are shipped is the "From" date of service on the claim.

The "To" date of service should reflect the expected end date of the dispensed product. Suppliers may have different billing patterns to reflect this expected end date. The key is to be consistent to avoid excessive product dispensed and potential denials.

Refill Requirement

Prior to delivering enteral nutrition, the supplier must contact the beneficiary to confirm the refill is necessary. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/ship date. Suppliers may deliver the product no sooner than 10 calendar days prior to the end of usage for the current product.

Noridian understands that an overlap in dates of service may occur to ensure the beneficiary does not run out of supplies. This is reflected in the examples below and depends on the suppliers billing patterns. 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.

Supply allowance HCPCS codes (B4034-B4036) are daily allowances which are considered all inclusive and therefore refill requirements are not applicable to these HCPCS codes.

Date Spanning

Below are two examples of how to date span enteral nutrition claims. The first example details a date span that matches the expected utilization of the product. The second example details a date span that matches the units billed. Both are considered correct and appropriate.

Span to Match Expected Utilization Example

When billing span dates supplier 1 determines the initial "anchor" date that does not change from month to month. This is done to avoid billing more than 12 monthly claims within a year. In the following example, the "anchor" date is the last or "To" date in the span date fields. Example for a 30 day supply of enteral nutrition and the daily feeding supply kit:

Initial delivery:

Span date on claim – 6/18/13 – 7/19/13

HCPCS code B4150 – 620 units

HCPCS code B4036 – 30 units

Product directly delivered or shipped on 6/18/13

Usage is expected to begin on 6/20/13 and last until 7/19/13

First refill:

Based on the refill contact requirements:

Earliest date to contact beneficiary, 14 days prior to end of expected usage of 7/19: 7/6/13

Earliest date to deliver/ship to beneficiary, 10 days prior to end of usage of 7/19: 7/10/13

Directly delivered or shipped on 7/12/13 – DOS is 7/12/13

Span date on claim – 7/12/13 – 8/18/13

HCPCS code B4150 – 620 units

HCPCS code B4036 – 30 units

Usage is expected to begin on 7/20/13 and last until 8/18/13

Note: The "From" dates is determined by the date the item was either directly delivered or shipped. The "To" date is the last day of expected usage.

Second refill:

Earliest date to contact beneficiary, 14 days prior to end of expected usage of 8/18: 8/5/13

Earliest date to deliver/ship to beneficiary, 10 days prior to end of usage of 8/18: 8/9/13

Directly delivered or shipped on 8/16/13 - DOS is 8/16/13

Span date on claim – 8/16/12 – 9/17/12

HCPCS code B4150 – 620 units

HCPCS code B4036 – 30 units

Usage is expected to begin on 8/19/13 and last until 9/17/13

Span Matches Units Dispensed Example

When billing span dates supplier 2 indicates the "To" date by adding the number of days the product is expected to last to the "From" date. The "To" date will not be the end date of the time period that the enteral is intended to be used. The "From" date reflects the date that the product was directly delivered or shipped, depending on the method of delivery. Example for a 30 day supply of enteral nutrition and the daily feeding supply kit are:

Initial delivery:

Span date on claim – 6/18/13 – 7/17/13

HCPCS code B4150 – 620 units

HCPCS code B4036 – 30 units

Product directly delivered or shipped on 6/18/13

Usage is expected to begin on 6/20/13 and last until 7/19/13

First refill:

Based on the refill contact requirements:

Earliest date to contact beneficiary, 14 days prior to end of expected usage of 7/19: 7/6/13

Earliest date to deliver/ship to beneficiary, 10 days prior to end of usage of 7/19: 7/10/13

Directly delivered or shipped on 7/12/13 – DOS is 7/12/13

Span date on claim – 7/12/13 – 8/10/13

HCPCS code B4150 – 620 units

HCPCS code B4036 – 30 units

Usage is expected to begin on 7/20/13 and last until 8/18/13

Note: The "From" dates is determined by the date the item was either directly delivered or shipped. The "To" date is the number of days the enteral and kits are expected to last from the "From" date. The span dates do not coincide with the dates the beneficiary actually used the products.

Second refill:

Earliest date to contact beneficiary, 14 days prior to end of expected usage of 8/18: 8/5/13

Earliest date to deliver/ship to beneficiary, 10 days prior to end of usage of 8/18: 8/9/13

Directly delivered or shipped on 8/12/13 - DOS is 8/12/13

Span date on claim – 8/12/12 – 9/10/12

HCPCS code B4150 – 620 units

HCPCS code B4036 – 30 units

Usage is expected to begin on 8/19/13 and last until 9/17/13

It is important to note that these are example scenarios and the delivery/usage will vary for each beneficiary. As part of the refill documentation requirements, the supplier must contact the beneficiary to find out how much enteral he/she has remaining to deliver or ship accordingly.

HCPCS B4185 and B4197 – Notification of Widespread Prepayment Probe Review

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

HCPCS: B4185
Description: PARENTERAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS

HCPCS: B4197
Description: PARENTERAL NUTRITION SOLUTION; COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, 74 TO 100 GRAMS OF PROTEIN - PREMIX

Widespread 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) data 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.
- DME Information Form (DIF).
- The ordering physician's in-person visit within 30 days prior to the initial certification or required recertification.
- Documentation to support the medical justification for Parenteral Nutrition. Documentation may include (but is not limited to) operative reports, x-ray reports, fecal fat test and dates of the test, small bowel motility study, serum albumin and date of the test and x-ray reports.
- Documentation to support the medical necessity of caloric intake outside the range of 20-35 cal/kg/day.
- Documentation to support the medical necessity for protein order, dextrose concentration or lipid use outside the range indicated in LCD L11576.
- Documentation to support continued medical use and continued medical need.
- Documentation to support refill requirements.
- Proof of delivery.
- The Advanced Beneficiary Notice (if applicable).
- Any other documentation to support the need for Parenteral Nutrition and all related accessories billed on the claim.

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

The ADR letter provided will also provide instruction for submitting documentation.

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

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 located at: http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4150)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code B4150. The quarterly edit effectiveness results from September 2013 through December 2013 are as follows:

- The B4150 review involved 289 claims, of which 210 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

The reason for denial is the physician order submitted has incomplete or missing elements. 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.

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 reason for denial is an invalid Proof of Delivery or no Proof of delivery was 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), 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 reason for denial is no documentation was received. 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 reason for denial is the refill requirements were incomplete or missing elements. 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/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.

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., Positive Airway Pressure and Respiratory Assist Device supplies) – The supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function . 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.

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Enteral Nutrition on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/enteral_nutrition.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4154)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code B4154. The quarterly edit effectiveness results from September 2013 through December 2013 are as follows:

- The B4154 review involved 747 claims, of which 597 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.

Primary Documentation Errors that Resulted in Denial of Claims

There was no documentation received in response to Additional Documentation Request (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 NSC.

There was no proof of delivery submitted or the proof of delivery submitted was invalid. 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.
- The detailed written order submitted was incomplete or missing elements.

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.

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.

Going Forward

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

ENTERNAL NUTRITION

Education Resources

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

Suppliers can also review specific policy resources for Enteral Nutrition on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/enteral_nutrition.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

ESRD

CMS Finalizes Policy and Payment Rate Changes for End-Stage Renal Disease Facilities in 2014

CMS strengthens incentives to improve outcomes for patients with ESRD

On November 22, CMS issued a final rule that updates Medicare policies and payment rates for 2014 for dialysis facilities paid under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS). CMS received extensive public comment on the proposed rule, issued in July. CMS carefully reviewed the comments and has decided to implement a three- to four-year transition for the drug utilization adjustment to the base rate mandated by Congress as part of the American Taxpayer Relief Act, and overall payments for 2014 will see a zero percent change.

The rule also finalized a 50 percent increase to the home dialysis training add-on payment adjustment that is made for both peritoneal dialysis and home hemodialysis training treatments.

While the ESRD PPS, implemented in 2011, was effective for renal dialysis services furnished on or after January 1, 2011, the statute provided for a 4-year transition period during which the ESRD facilities were paid a blended payment with a portion of payments based on the composite rate methodology and a portion based on the new PPS rate. In 2014, the final year of the 4-year transition period, all ESRD facilities will be paid 100 percent of the ESRD PPS rate for renal dialysis services furnished on or after January 1, 2014.

The final rule will also strengthen the ESRD Quality Incentive Program (QIP), which creates incentives for dialysis facilities to improve the quality of care and patient outcomes for beneficiaries diagnosed with ESRD. For the ESRD QIP Payment Year (PY) 2016 program (which will rely on measures of dialysis facility performance during 2014), CMS is finalizing 11 measures addressing infections, anemia management, dialysis adequacy, vascular access, mineral metabolism management, and patient experience of care. We are also finalizing the method by which performance scores will be calculated by weighting clinical measures at 75 percent of the total performance score and weighting the reporting measures at 25 percent. The ESRD QIP will reduce payments to ESRD facilities that do not meet or exceed certain performance standards.

Both the ESRD PPS and the ESRD QIP were mandated by the Medicare Improvements for Patients and Providers Act of 2008. The ESRD PPS is intended to improve efficiency and reduce incentives to use more items and services than needed for appropriate care, while the ESRD QIP is intended to promote improvement in the quality of care provided to Medicare beneficiaries with ESRD.

Additionally, the final rule includes several provisions related to Medicare policies on durable medical equipment (DME). CMS is a finalizing clarification of the 3-year minimum lifetime requirement for DME and the distinction between routinely purchased and capped rental DME. The rule also finalizes the implementation of budget-neutral fee schedules for splints and casts, and intraocular lenses inserted in a physician's office as well as a few technical amendments and corrections to existing regulations related to payment for durable medical equipment, prosthetics, and orthotics items and services.

Full text of this excerpted CMS press release (issued November 22).

- Final Rule.
- ESRD Center.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code A4253. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from September 1, 2013, through November 30, 2013, resulted in an overall error rate of 61%.

Primary Documentation Errors that Resulted in Denial of Claims

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. The supplier standards can be found in 424 CFR Section 424.57(c).

The refill requirements were not met. For services performed prior to 11/01/12 – The beneficiary has nearly exhausted the supply of test strips and lancets, or useful life of one lens shield cartridge previously dispensed.

For services performed on or after 11/01/12 – 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.

The documentation submitted did not support the actual testing frequency that corroborates the quantity of supplies that were dispensed. For services performed prior to 11/01/12 – 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) or in the supplier's records (e.g., 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.

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.

The order submitted was invalid.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

Going Forward

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

Education Resources

The following references were used in the review of your claims and can be accessed on our Noridian website at http://www.noridianmedicare.com:

Glucose Monitors

- Local Coverage Determination L196.
- Policy Article A33673.
- National Coverage Determination 40.20.
- Consolidated Resources – Glucose Monitors.

In addition, the following references are educational resources related to the HCPCS code being reviewed:

- Documentation Checklists
  https://www.noridianmedicare.com/dme/coverage/checklists.html
- Physician Resource Letters
  https://www.noridianmedicare.com/dme/coverage/resources.html
- Policy Specific Training/Events
  https://www.noridianmedicare.com/dme/train

Noridian provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Glucose Monitors (HCPCS A4253KS)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A4253KS. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The A4253KS review involved 2,687 claims, of which 2,578 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

Primary Documentation Errors that Resulted in Denial of Claims

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.

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 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.

The medical records submitted did not support the specific reason for the additional materials for the particular beneficiary. 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

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Glucose Monitors on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/glucose_monitors.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

GLUCOSE MONITORS

Reminder – National Mail Order Suppliers and Testing Supplies

Suppliers selected for national mail order of diabetic testing supplies are reminded of the following regulations governing the provision of testing supplies:

- Contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. **The contract supplier is prohibited from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies.** The contract supplier may not furnish information about alternative brands to the beneficiary unless the beneficiary requests such information. [Emphasis added – See 42 CFR 414.422(e)(3)].
- Physicians have the option of prescribing a specific brand of glucose monitor if the physician determines that the particular brand or mode of delivery would avoid an adverse medical outcome for the beneficiary. If the physician prescribes a specific brand of monitor, the supplier has three (3) options:
    1. Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner.
    2. Consult with the physician or treating practitioner to find an appropriate alternative brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner.
    3. Assist the beneficiary in locating a contract supplier that can furnish the particular brand. (See 42 CFR 414.420)

CMS and the DME MACs are monitoring utilization data and will refer to the appropriate contractor(s) for further investigation any National Mail Order supplier who is suspected of violating these and other terms of their contract.

Glucose monitors are covered under the Durable Medical Equipment benefit; therefore, the 5-year reasonable useful lifetime (RUL) rules apply. Additional information on RUL and replacement of DME may be found in the Medicare Benefit Policy Manual (Internet-only Manual, Publ. 100-2), Chapter 15, Section 110.2. Routine replacement or replacement due to a change in suppliers is non-covered by Medicare.

HOSPITAL BEDS

Quarterly Results of Widespread Prepayment Review of Claims for Hospital Beds (HCPCS E0260)

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code E0260. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The E0260 review involved 1,285 claims, of which 1,109 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 87%.

Primary Documentation Errors that Resulted in Denial of Claims

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.
- The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.

- 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.
- The patient requires traction equipment, which can only be attached to a hospital bed.

No documentation was provided in response to the additional documentation request (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 Section 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. 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 proof of delivery submitted was invalid. 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. 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.

Going Forward

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

Education 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Home Health Consolidated Billing Quarterly HCPCS Codes Update

MLN Matters® Number: MM8539
Related Change Request (CR) #: CR 8539
Related CR Release Date: December 13, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R2835CP
Implementation Date: April 7, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8539, which provides the annual update to Home Health (HH) consolidated billing effective for dates of service on or after April1, 2014. The new codes were effective January 1, 2014, but were overlooked and a 2014 annual HH consolidated billing update was not published. The following of Healthcare Common Procedure Coding System (HCPCS) codes are added to the HH consolidated billing non-routine supply code list:

- A7047 – Oral Interface Used With Respiratory Suction Pump, each.
- A6531 –Gradient Compression Stocking, Below Knee, 30-40 MMHG, Each.
- A6532 – Gradient Compression Stocking, Below Knee, 40-50 MMHG, Each.

Note: A7047 is a new HCPCS code in 2014. Codes A6531 and A6532 are existing codes added due to their similarity to code A6545, which has been subject to HH consolidated billing since 2009.

The following HCPCS codes are added to the HH consolidated billing therapy code list:

- 92521 – Evaluation of speech fluency (eg, stuttering, cluttering).
- 92522 – Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria).
- 92523 – with evaluation of language comprehension and expression (eg, receptive and expressive language).
- 92524 – Behavioral and qualitative analysis of voice and resonance.

These four new speech evaluation codes replace code 92506. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates.

No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Additional Information

The official instruction, CR 8539, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2835CP.pdf on the CMS website.

ICD-10

ICD-10 Limited End to End Testing with Submitters

MLN Matters® Number: MM8602
Related Change Request (CR) #: CR 8602
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1352OTN
Effective Date: July 7, 2014
Implementation Date: July 7, 2014

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8602 which instructs providers and clearinghouses on how to volunteer to be chosen for ICD-10 End to End testing with Medicare in July 2014. Potential testers must complete the volunteer form on the MAC website by March 24, 2014.

Background

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2014. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with the Centers for Medicare & Medicaid Services (CMS).

Change Request (CR) 8602 will allow for a small subset of Medicare claims submitters to test with MACs and the Common Electronic Data Interchange (CEDI) contractor to demonstrate that CMS systems are ready for the ICD-10 implementation. This additional testing effort will further ensure a successful transition to ICD-10.

To facilitate this testing, CR8602 requires MACs to do the following:

- Conduct a limited end to end testing with submitters in July 2014. Test claims will be submitted July 21-25, 2014.
- Each MAC (and CEDI with assistance from DME MACs) will select 32 submitters to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will select 16 submitters.) Testers will be selected randomly from a list of volunteers. At least five, but not more than ten of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- By March 7, 2014, the MACs and CEDI will post a volunteer form to their website to collect volunteer information with which to select volunteers. The form will provide information to verify that volunteers are ready to test, meet the requirements to test, and collect needed data about the tester (how they submit claims, what type of claims will be tested, etc.). Volunteers must submit the completed forms to the MACs and CEDI by March 24, 2014.

- By April 14, 2014, the MACs and CEDI (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set).
    - What dates of service may be used for testing.
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files).
    - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than 5 NPIs and 10 HICNs per submitter).
    - Notice that if more than 50 claims are submitted, they may not be processed.
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed.
    - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDI (for the DME MACs) will collect information from the selected test volunteers to request the HICNs, NPIs, and Provider Transaction Access Numbers (PTANs) the testers will use during the testing. The forms for this information must be completed and returned to the MAC/CEDI by May 2, 2014. If these forms are not returned by May 2, the tester may lose the opportunity to test.
- CEDI will instruct suppliers to submit claims with ICD-10 codes with Dates of Service (DOS) 10/1/2014 through 10/15/2014. They may also submit claims with ICD-9 codes with DOS before 10/1/2014.
- MACs will instruct testers to submit test claims with ICD-10 codes with DOS on or after 10/1/2014. They may also submit test claims with ICD-9 codes with DOS before 10/1/2014.
- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the Electronic Remittance Advices (ERAs) from testing. MACs and CEDI will provide information to the testers on who to contact for testing questions. There may be separate contacts for front end questions and remittance questions.
- MACs will post an announcement about the testing to their websites.

Additional Information

The official instruction, CR 8602, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1352OTN.pdf on the CMS website.

ICD-10 Testing with Providers through Common Edits and Enhancements Module and CEDI

MLN Matters® Number: MM8465
Related Change Request (CR) #: CR 8465
Related CR Release Date: February 26, 2014
Related CR Transmittal #: R1353OTN
Effective Date: December 3, 2013
Implementation Date: March 3, 2014

Note: This article was revised on February 27, 2014, to reflect a revised CR that provides additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (page 2 in bold). The transmittal number, CR release date and link to the CR were also changed. All other information remains the same.

Provider Types Affected

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

What Providers Need to Know

This article is based on Change Request (CR) 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

For dates of service of October 1, 2014 (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.

Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013 through March 3, 2014), since testing does not support future dated claims.

Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.

Testing will not confirm claim payment or produce remittance advice.

MACs and CEDI will be staffed to handle increased call volume during this week.

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014.

CR8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week has been created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week will give trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC and the CEDI website as well as the CMS website.

The testing week will be March 3 through March 7, 2014.

Testing Week Information:

- Your MAC will announce and actively promote the testing week via listserv messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an email address for the trading partners to provide registration information. The registration site or email address information will be available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- On or before March 18, 2014, your contractor will report the following to CMS:
    - Number of trading partners conducting testing during the testing week.
    - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
    - Percent of test claims accepted versus rejected.
    - Report of any significant issues found during testing.

Additional Information

The official instruction, CR8465, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1353OTN.pdf on the CMS website.

Medicare FFS Claims Processing Guidance for Implementing ICD-10 – A Re-Issue of MM7492

MLN Matters® Number: SE1408

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013 implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2014, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key Points of SE1408

General Reporting of ICD-10

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

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2014. Institutional claims containing ICD-9 codes for services on or after October 1, 2014, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2014, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2014, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2014, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2014, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2014, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2014. Institutional claims containing ICD-10 codes for services prior to October 1, 2014, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2014, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2014, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2014, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2014. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
13X	Outpatient Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
23X	Skilled Nursing Facilities (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	**Note:** RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2014.	*See Note
34X	Home Health – (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
71X	Rural Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/20143 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
76X	Community Mental Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
81X	Hospice – Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
82X	Hospice – Non hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2014, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/14 but end on 10/1/14 are to be billed with ICD-9 diagnosis codes and use 9/30/14 as both the FROM and THROUGH date.	FROM

Table D – Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/14 (i.e., the FROM date of service occurs prior to 10/1/14 and the TO date of service occurs after 10/1/14).	FROM

Additional Information

You may also want to review SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014.

Medicare FFS ICD-10 Testing Approach

MLN Matters® Number: SE1409 Revised

Note: This article was revised on February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing.

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare Fee-For-Service (FFS) provider community is ready.

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

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

- Alpha testing is performed by each FFS claims processing system maintainer for 4weeks.

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

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

Provider-Initiated Beta Testing Tools

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

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website.
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 Integrated Outpatient Code Editor (IOCE) that utilizes ICD-10-CM located at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf on the CMS website. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for Local Coverage Determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

Acknowledgement Testing

CMS will offer ICD-10 acknowledgement testing from March 3–7, 2014. This testing will allow all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

End-to-End Testing

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

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

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

MLN Matters® Number: MM8506
Related Change Request (CR) #: CR 8506
Related CR Release Date: February 5, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R159NCD
Implementation: October 1, 2014

Provider Types Affected

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.
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/R159NCD.pdf on the CMS website.

Special Instructions for ICD-10-CM Coding on Home Health Episodes that Span October 1, 2014

MLN Matters® Number: SE1410 Revised

Note: This article was revised on February 27, 2014, to correct an entry in the table on page 4. The last row and third column of the table should have indicated "OASIS-C". All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and other covered entities who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in home health (HH) care settings.

Provider Action Needed

This MLN Matters® Special Edition (SE) 1410 alerts providers that on October 1, 2014 all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.

Background

In 2011 the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date. Recently, CMS issued an updated article (SE1408) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf, which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2014 and ends in October 2014. MLN Matters® Article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2014. This article provides further details regarding HH claims for episodes that span the October 1 date.

Key Points of This Article

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

1. The claim "From" date (episode start date).
2. The Outcome and Assessment Information Set (OASIS) assessment completion date (OASIS item M0090 date).
3. The claim "Through" date.

Episodes Starting Before October 1, 2014 with OASIS Completion Dates Before October 1, 2014. In the case of initial HH episodes, the OASIS assessment must be completed within 5 days of the start of care. The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode. In the case where the episode start of care date is before October 1, 2014 and the M0090 date is also before October 1, 2014, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim "Through" date. On Requests for Anticipated Payment (RAPs), Medicare billing instructions require that the "From" and "Through" dates are the same. So if the episode begins in September 2014, the "From" and "Through" dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2014, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2014, so these claims will have claim "Through" dates of October 1, 2014 or later. The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will:

- "Allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes."

This does not mean that all episodes must be re-coded under ICD-10-CM. CMS intends to avoid any extra burden that could result from requiring HHAs to code these episodes under both the ICD-9-CM and ICD-10-CM systems. To avoid that, we advise HHAs to use the General Equivalence Mappings (GEMs) or other convenient translation tables to derive ICD-10-CM codes for use on claims for episodes that span October 1, 2014. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

This may result in some inconsistency between the HIPPS code on the claim and the ICD-10-CM codes. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2014 but the episode ends in October 2014 (see table below).

Episodes Starting Before October 1, 2014 with OASIS Completion Dates in October 2014. There may be cases where the episode start of care date is before October 1, 2014 and, due to the 5 day completion window, the M0090 date is in October 2014. For example, an initial episode with a start of care date of September 28, 2014 could have an M0090 date of October 2, 2014. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

The RAP for this example would have "From" and "Through" dates of September 28, 2014. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

As with the previous category of episodes that span October 1, CMS does not require these cases to be coded in both systems. We again advise that HHAs use the GEMs or other convenient translation tables to derive ICD-9-CM codes for use on the RAPs for episodes. Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations. The ICD-9-CM codes are simply required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification Episodes Beginning in the First Days of October 2014. In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2014 could have an M0090 date of September 28, 2014. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code.

But in this case, both the RAP and claim will require ICD-10-CM codes since the "Through" date on both will be after October 1, 2014. HHAs will use the GEMs or other convenient translation tables to derive ICD-10-CM codes for use on these RAPs and claims.

The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts.

The following table summarizes the above scenarios:

Type of OASIS Assessment	RAP "From/ Through" Dates	OASIS M0090 Date/OASIS Version	Claim "Through" Date	Diagnosis Coding Used on OASIS	Diagnosis Coding Used on RAP	Diagnosis Coding Used on Claim
Start of Care/ Resumption of Care	9/28/2014	9/30/2014 OASIS-C	11/26/2014	ICD-9-CM	ICD-9-CM	Mapped ICD-10-CM
Recertification	9/28/2014	9/25/2014 OASIS-C	11/26/2014	ICD-9-CM	ICD-9-CM	Mapped ICD-10-CM
Start of Care/ Resumption of Care	9/28/2014	10/2/2014 OASIS-C1	11/26/2014	ICD-10-CM	Mapped ICD-9-CM	ICD-10-CM
Recertification	10/2/2014	9/28/2014 OASIS-C	11/30/2014	ICD-9-CM	Mapped ICD-10-CM	Mapped ICD-10-CM

To access the GEMs, you may go to http://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-CM-and-GEMs.html on the CMS website.

Additional Information

To find additional information about ICD-10, visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on CMS website.

INCARCERATED BENEFICIARIES

Incarcerated Beneficiary Claim Denials: Revised Beneficiary Liability and Messages – Revised

MLN Matters® Number: MM8488 Revised
Related Change Request (CR) #: CR 8488
Related CR Release Date: December 27, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1330OTN
Implementation Date: April 7, 2014

Note: This article was revised on January 15, 2014, to reflect the revised CR8488 issued on December 27, 2013. In the article, the effective and implementation dates are changed and the CARC and RARC descriptions are changed to reflect the revised CR8488 descriptions. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised.

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administration Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries while they are in Federal, State, or local custody.

Provider Action Needed

This article is based on Change Request (CR) 8488 which instructs Medicare Claims Administration Contractors to use an updated Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Group Code when denying claims for services furnished to incarcerated Medicare beneficiaries. See the Background and Additional Information Sections of this article for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

According to Federal regulations at 42 CFR 411.4, Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service, and no other person or organization has a legal obligation to provide or pay for the service. Refer to the Electronic Code of Federal Regulations (e-CFR) at http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=1270613eb7cae1ed8c62899034b0eca2&rgn=div8&view=text&node=42:2.0.1.2.11.1.35.3&idno=42 on the Internet. This exclusion presumptively applies to individuals who are incarcerated.

Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency. Also, under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare, the claims are rejected by the Common Working File (CWF) and denied by the claims processing contractors. Per previously issued instructions (most recently, CR7678, Transmittal 1054, issued 3/7/2012; see related MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7678.pdf), MACs use the following remittance advice messages and Group Code when denying such claims:

- C**laim Adjustment Reason Code (CARC): 96** – "Non-covered charges."
- **Remittance Advice Remark Code (RARC): N103** – "Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt."
- **Group Code: PR** – Patient Responsibility.

CR8488 revises the remittance advice messages and group code used for denials of claims for services furnished to incarcerated beneficiaries.

MACs will begin using the following new CARC code when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody:

- **CARC: 258** – Claim/service is not covered when patient is in custody/ incarcerated. Applicable federal, state or local authority may cover this claim/service.

In addition, MACs will begin using the following revised RARC N103 language when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody:

- **RARC: N103** – "Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/Local authority as appropriate."

MACs will begin using the following Group Code to assign proper liability when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody so that the provider or supplier should seek repayment for the cost of its services provided from the authority that was in custody of the beneficiary on the date of service:

- **Group Code: OA** – Other Adjustment.

INCARCERATED BENEFICIARIES

Other than the above, MACs will continue to use existing Remittance Advice codes and messages and MSN language already in place when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody.

Additional Information

The official instruction, CR8488 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1330OTN.pdf on the CMS website.

LCD AND POLICY ARTICLE REVISIONS

LCD and PA Revisions Summaries

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.

November 15, 2013

Nebulizers

LCD

Revision Effective Date: 11/01/2013 (November 2013 Publication)

HCPCS CODES AND MODIFIERS:

Added: HCPCS code A7018

Policy Article

Revision Effective Date: 11/01/2013 (November 2013 Publication)

NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:

Revised: Refill Information

November 27, 2013

Glucose Monitor

Policy Article

Revision Effective Date: 01/01/2014

CODING GUIDELINES:

Revised: Billing of testing supplies dispensed with initial issue of glucose monitor

Revised: Bundling table

December 19, 2013

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

LCD

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Titration PSG language and qualifying patients for oxygen therapy

January 30, 2014

Tracheostomy Care Supplies

Policy Article

Revision Effective Date: 03/01/2014

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES and CODING GUIDELINES
Added: AU modifier for A5120 (wipes or swabs) in the same manner as is used for A4450 & A4452

February 13, 2014

Intravenous Immune Globulin

LCD

Revision Effective Date: 01/01/2014

HCPCS CODES:

Added: J1556

Suction Pumps

LCD

Revision Effective Date: 01/01/2014

COVERAGE, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: A7047 denial statement

HCPCS CODES AND MODIFIERS:

Added: A7047

Revised: A9272 narrative

ICD-9 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:

Added: Code for E0600, A7002 and A7047

DOCUMENTATION REQUIREMENTS:

Added: ICD-9 requirement for E0600, A7002 and A7047

Policy Article

Revision Effective Date: 01/01/2014

CODING GUIDELINES:

Revised: Definition of E0600 to include respiratory suction devices other than those designed to remove secretions

Added: A7047

Revised: A9272 definition to include items previously coded as A9270

February 27, 2014

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Section V.A to specify vincristine coverage is only for the non-liposomal form of the drug

Added: Information that item(s) in policy are subject to ACA 6407 requirements

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (February 2014 publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (requirements effective 07/01/2013)

Ostomy Supplies

LCD

Revision History Effective Date: 01/01/2014

HCPCS CODES AND MODIFIERS:

Revised: A5081 narrative description

Pressure Reducing Support Surfaces - Group 3

LCD

Revision Effective Date: 11/01/2013 (February 2014 publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements.

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (February 2014 publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (requirements effective 07/01/2013)

March 6, 2014

Automatic External Defibrillators LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (revisions effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (revisions effective 07/01/2013)

Hospital Beds and Accessories

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (revisions effective 07/01/2013)

Manual Wheelchair Bases

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

Added: ACA 6407 information (requirements effective 07/01/2013)

Mechanical In-exsufflation Devices

LCDRevision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements(effective 07/01/2013)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Osteogenesis Stimulators

LCD

Revision Effective Date: 11/01/2013

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Patient Lifts

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Speech Generating Devices

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

March 13, 2014

Glucose Monitors

LCD

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: Gestational diabetes (648.00-648.04)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 01/01/2014 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (requirements effective 07/01/13)

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (requirements effective 07/01/13)

Immunosuppressive Drugs

LCD

Revision Effective Date: 01/01/2014

HCPCS CODES AND MODIFIERS:

Added: J7508

Revised: J7507 narrative description

Nebulizers

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/13)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Orthopedic Footwear

LCD

Revision Effective Date: 01/01/2014

HCPCS CODES AND MODIFIERS:

Revised: L3100 and L3170 narrative description

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Statement about bundled payment category

Added: Additional clarification about concurrent use of oxygen in OSA testing

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

HCPCS CODES AND MODIFIERS:

Added: E1352

DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 01/01/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Clarification about separate billing for stationary and portable contents

Added ACA 6407 material (effective 07/01/2013)

CODING GUIDELINES:

Added: E1352

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

LCD

Revision Effective Date: 01/01/2014 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements effective 07/01/2013)

HCPCS CODES AND MODIFIERS:

Revised: Narrative of code E0601

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Wheelchair Options/Accessories

LCD

Revision Effective Date: 11/01/2013 (March 2014 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)

HCPCS CODES AND MODIFIERS:

Revised: HCPCS Narrative of E2300 and E2301

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 11/01/2013 (March 2014 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements (effective 07/01/2013)

Revised: Restored K0077 to Manual Wheelchair Base, Power Wheelchair Base Groups 1 and 2 and Power Wheelchair Base Groups 3, 4 and 5 Column II of the bundling table

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.

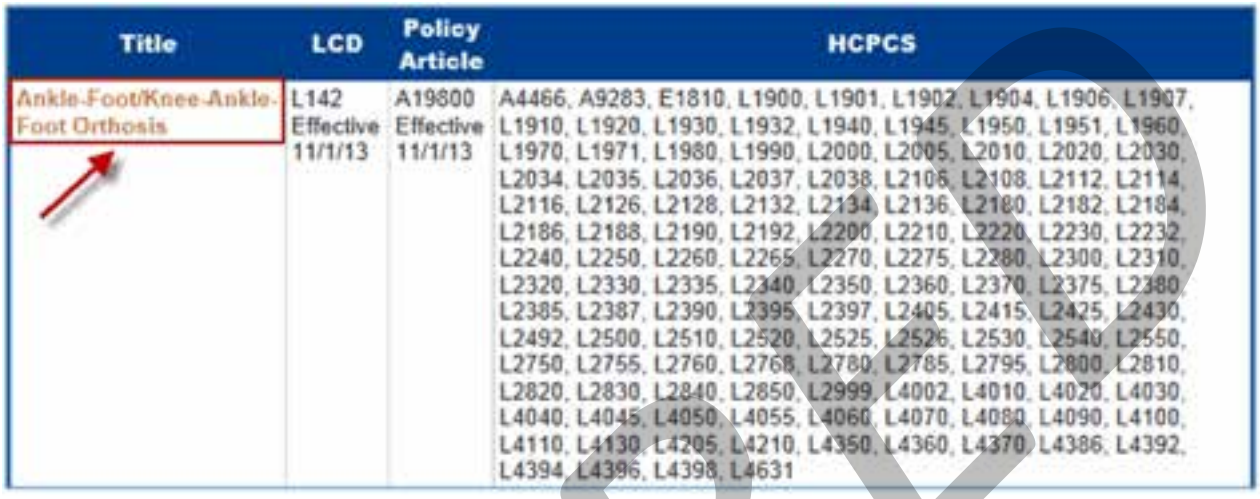
Noridian Healthcare Solutions, LLC Name Update to LCDs and Articles

Noridian would like to inform you of a recent revision completed for our Local Coverage Determinations (LCDs) and articles to update our name to Noridian Healthcare Solutions, LLC. You will notice that the effective date of each of these documents will be changed to November 1, 2013. Each document will also contain a revision history that states "This LCD/article was revised to reflect the corporate name change from Noridian Administrative Services, LLC to Noridian Healthcare Solutions, LLC that was effective on 05/01/2013. No other changes were made in this revision."

The LCD and Policy Articles can be found at https://www.noridianmedicare.com/dme/coverage/lcd.html.

Update to LCD and Policy Article Format

Noridian would like to inform suppliers of a change that is being implemented in regards to how to view the LCD and Policy Articles on the Noridian website. The LCD and Policy Articles will be combined into one document instead of two separate documents. The layout of the webpage and content in the documents will remain the same. Instead of how you previously clicked on the LCD or Policy Article number, you will need to click on the policy title:



Title	LCD	Policy Article	HCPCS
Ankle-Foot/Knee-Ankle-Foot Orthosis	L142 Effective 11/1/13	A19800 Effective 11/1/13	A4466, A9283, E1810, L1900, L1901, L1902, L1904, L1906, L1907, L1910, L1920, L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2106, L2108, L2112, L2114, L2116, L2126, L2128, L2132, L2134, L2136, L2180, L2182, L2184, L2186, L2188, L2190, L2192, L2200, L2210, L2220, L2230, L2232, L2240, L2250, L2260, L2265, L2270, L2275, L2280, L2300, L2310, L2320, L2330, L2335, L2340, L2350, L2360, L2370, L2375, L2380, L2385, L2387, L2390, L2395, L2397, L2405, L2415, L2425, L2430, L2492, L2500, L2510, L2520, L2525, L2526, L2530, L2540, L2550, L2750, L2755, L2760, L2768, L2780, L2785, L2795, L2800, L2810, L2820, L2830, L2840, L2850, L2999, L4002, L4010, L4020, L4030, L4040, L4045, L4050, L4055, L4060, L4070, L4080, L4090, L4100, L4110, L4130, L4205, L4210, L4350, L4360, L4370, L4386, L4392, L4394, L4396, L4398, L4631

To help suppliers navigate the one document better, we have also put a link at the top of the LCD to jump to the Policy Article as well as a link at the bottom of the document to jump to the top of either item.

Coding Guideline – K0900 (Custom Durable Medical Equipment, other than Wheelchairs)

Joint DME MAC Publication

A new HCPCS code, K0900, has been created for use with custom fabricated durable medical equipment other than wheelchairs. 42 CFR §414.224(a) describes the requirements for custom fabricated, stating in order to be considered a customized DME item, a covered item (including a wheelchair) must be:

1. Uniquely constructed or substantially modified for a specific beneficiary according to a physician's description and orders.
2. So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

Supplier and manufacturers must remember that the definition of custom fabricated does not include:

1. Items that are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items).
2. Items that have been assembled by a supplier, or ordered from a manufacturer, who makes available customized features, modification or components intended for an individual patient's use in accordance with instructions from the patient's physician.

These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in equipment being considered as customized.

§414.224(b) further provides that the lump-sum payment made for purchase of the customized item is based on the Medicare contractor's individual consideration and judgment of a reasonable payment amount for each item. The contractor's individual consideration takes into account:

1. Written documentation on the item's costs (including design, fabrication, and assembly costs), including at least the costs of labor (to the extent that they are reasonable) of those actually performing the customization.
2. The types of materials (to the extent that they are reasonable) used in custom fabricating or substantially modifying an item.

In order to determine a reimbursement amount, the supplier must provide a detailed description of each phase of the construction process, materials used, the labor skills needed to fabricate or modify the item, etc. (not all-inclusive). When submitting claims for items using K0900 supplier must have in their files:

1. A detailed written order for the item.
2. Information from the medical record justifying that the applicable medical necessity requirements from the relevant policy are met.
3. Information from the medical record showing the ordering physician's description of the item to be provided.
4. Information from the supplier providing a detailed description of the item provided including a cost breakdown (for time and each material used in fabrication of the item); construction and/or assembly description; and an explanation about why the item should be considered as custom fabricated.

This information must be available upon request.

Pricing differentials between the fee for an established HCPCS code and the suppliers cost or desired charge for any item are not a justification for the use of K0900 or any other NOC (not-otherwise-classified) code such as E1399 [DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS]. Correct coding rules require the use of the most specific HCPCS for any 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 located on the PDAC website: https://www.dmepdac.com.

E0147 Walker Reminder

A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for beneficiaries who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. When code E0147 is billed, the claim must include the manufacturer's name and product name/number in the narrative field of the claim. The narrative field is Item 19 of the 1500 claim form or the NTE segment of the 2400 Loop of an electronic media claim. Suppliers should be aware that any claim with code E0147 that is billed without a narrative will be denied as a contractual obligation with reason code 50 and remark code N115.

The only walkers that may be billed using code E0147 are those products 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.

Please see the Local Coverage Determination and Policy Article for additional information regarding walkers.

Manual Wheelchair Bases

Recently it has been brought to the attention of the Pricing, Data Analysis and Coding Contractor (PDAC) that manufacturers are submitting incomplete wheelchair bases on Coding Verification Review Applications. For Medicare payment purposes a manual wheelchair HCPCS codes describes a complete product as described in the bundling table contained in the Wheelchair Options and Accessories LCD. Column I codes contains all of the items listed in Column II.

Column I	Column II
Power Operated Vehicle (K0800–K0812)	All options and accessories
Rollabout Chair (E1031)	All options and accessories
Transport Chair (E1037, E1038, E1039)	All options and accessories except E0990, K0195
Manual Wheelchair Base (E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009)	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072
Power Wheelchair Base Groups 1 and 2 (K0813–K0843)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0098
Power Wheelchair Base Groups 3, 4, and 5 (K0848–K0891)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0098
E0973	K0017, K0018, K0019
E0950	E1028
E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems (E1002, E1003, E1004, E1005, E1006, E1007, E1008)	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1009, E1010	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E2325	E1028
E1020	E1028
K0039	K0038
K0045	K0043, K0044
K0046	K0043
K0047	K0044
K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047
K0069	E2220, E2224
K0070	E2211, E2212, E2224
K0071	E2214, E2215, E2225, E2226

Column I	Column II
K0072	E2219, E2225, E2226
K0077	E2221, E2222, E2225, E2226
K0195	E0995, K0042, K0043, K0044, K0045, K0046, K0047

A manual wheelchair base includes but is not limited to:

- A complete frame.
- Propulsion wheels and brakes.
- Casters.
- A seat or seat pan (which can accommodate a wheelchair seat cushion or other seating system).
- A back frame.
- Standard leg and footrests.
- Armrests.
- Safety accessories (other than those separately billable in the Wheelchair Accessories Local Coverage Determination).

As described above, the following HCPCS codes are included in the allowance for the base wheelchair on initial issue:

E0967 MANUAL WHEELCHAIR ACCESSORY HAND RIM WITH PROJECTIONS ANY TYPE EACH

E0981 WHEELCHAIR ACCESSORY SEAT UPHOLSTERY REPLACEMENT ONLY EACH

E0982 WHEELCHAIR ACCESSORY BACK UPHOLSTERY REPLACEMENT ONLY EACH

E0995 WHEELCHAIR ACCESSORY CALF REST/PAD EACH

E2205 MANUAL WHEELCHAIR ACCESSORY HANDRIM WITHOUT PROJECTIONS (INCLUDES ERGONOMIC OR CONTOURED) ANY TYPE REPLACEMENT ONLY EACH

E2206 MANUAL WHEELCHAIR ACCESSORY WHEEL LOCK ASSEMBLY COMPLETE EACH

E2210 WHEELCHAIR ACCESSORY BEARINGS ANY TYPE REPLACEMENT ONLY EACH

E2220 MANUAL WHEELCHAIR ACCESSORY SOLID (RUBBER/PLASTIC) PROPULSION TIRE ANY SIZE EACH

E2221 MANUAL WHEELCHAIR ACCESSORY SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE) ANY SIZE EACH

E2222 MANUAL WHEELCHAIR ACCESSORY SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL

E2224 MANUAL WHEELCHAIR ACCESSORY PROPULSION WHEEL EXCLUDES TIRE ANY SIZE EACH

E2225 MANUAL WHEELCHAIR ACCESSORY CASTER WHEEL EXCLUDES TIRE ANY SIZE REPLACEMENT ONLY

E2226 MANUAL WHEELCHAIR ACCESSORY CASTER FORK ANY SIZE REPLACEMENT ONLY EACH

K0015 DETACHABLE NON-ADJUSTABLE HEIGHT ARMREST EACH

K0017 DETACHABLE ADJUSTABLE HEIGHT ARMREST BASE EACH

K0018 DETACHABLE ADJUSTABLE HEIGHT ARMREST UPPER PORTION EACH

K0019 ARM PAD EACH

K0042 STANDARD SIZE FOOTPLATE EACH

K0043 FOOTREST LOWER EXTENSION TUBE EACH

K0044 FOOTREST UPPER HANGER BRACKET EACH

K0045 FOOTREST COMPLETE ASSEMBLY

K0046 ELEVATING LEGREST LOWER EXTENSION TUBE EACH

K0047 ELEVATING LEGREST UPPER HANGER BRACKET EACH

K0050 RATCHET ASSEMBLY

K0052 SWINGAWAY DETACHABLE FOOTRESTS EACH

K0069 REAR WHEEL ASSEMBLY COMPLETE WITH SOLID TIRE SPOKES OR MOLDED EACH

K0070 REAR WHEEL ASSEMBLY COMPLETE WITH PNEUMATIC TIRE SPOKES OR MOLDED EACH

K0071 FRONT CASTER ASSEMBLY COMPLETE WITH PNEUMATIC TIRE EACH

K0072 FRONT CASTER ASSEMBLY COMPLETE WITH SEMI-PNEUMATIC TIRE EACH

Manual wheelchairs submitted to the PDAC that are incomplete will receive a "No HCPCS Code Assigned" designation. If the manual wheelchair base is incomplete, any accessories associated with the application will not be processed.

Manual Wheelchairs Home Assessment Requirement Reminder

The home assessment requirements for manual wheelchairs for use inside the home (E1037 – E1039, E1161, K0001 – K0009) is covered if Criterion A, B, C, D, and E are met, as well as Criterion F or G is met according to the Coverage Guidelines portion of the Local Coverage Determination (LCD) and Policy Article (PA) for Manual Wheelchair Bases.

Noridian has many resources to help suppliers ensure these requirements are met. The Manual Wheelchair Documentation Checklist breaks the coverage criteria down into bullet-point list as indicated below:

Home Assessment

- Must be documented in the medical record or elsewhere by the supplier:
    - Physical layout.
    - Surfaces.
    - Obstacles.
- May be done directly by visiting the beneficiary's home.
- May be done indirectly based upon information provided by the beneficiary or their designee:
    - At time of delivery, supplier must verify that the home can accommodate the item delivered.

For further clarification of the home assessment and other criterion, please refer to the Manual Wheelchair Bases Local Coverage Determination LCD L11454 and related Policy Article PA A25378.

PMD Prior Authorization Requests (PAR) Top Reasons for Non-Affirmation

The Jurisdiction D DME MAC Medical Review Department provides suppliers with the opportunity to request prior authorization approval for power mobility devices (PMDs). The top non-affirm reasons from June 2013 through August 2013 are described below.

Top Reasons for Non-Affirmed Decisions

The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home.

The beneficiary's medical documentation does not support Criterion C.:

C. The beneficiar y 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 non-powered accessories.

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:

B. 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 documentation does not indicate that the use of a power operated vehicle (POV) has been excluded.

The beneficiary's medical records do not support that the beneficiary does not meet coverage Criterion D for a power operated vehicle (POV).

D. The beneficiary is able to:

- Safely transfer to and from a POV.
- Operate the tiller steering system.
- Maintain postural stability and position while operating the POV in the home.

The documentation does not support the criteria for the PMD requested.

A POV or power wheelchair with Captain's Chair is not appropriate for a beneficiary who needs a separate wheelchair seat and/or back cushion. If a skin protection and/or positioning seat or back cushion that meets coverage criteria (see Wheelchair Seating LCD) is provided with a POV or a power wheelchair with Captain's Chair, the POV or PWC will be denied as not reasonable and necessary. (Refer to Wheelchair Seating LCD and Policy Article for information concerning coverage of general use, skin protection, or positioning cushions when they are provided with a POV or power wheelchair with Captain's Chair.)

For beneficiaries who do not have special skin protection or positioning needs, a power wheelchair with Captain's Chair provides appropriate support. Therefore, if a general use cushion is provided with a power wheelchair with a sling/solid seat/back instead of Captain's Chair, the wheelchair and the cushion(s) will be covered only if either criterion 1 or criterion 2 is met:

1. The cushion is provided with a covered power wheelchair base that is not available in a Captain's Chair model – i.e., codes K0839, K0840, K0843, K0860 – K0864, K0870, K0871, K0879, K0880, K0886, K0890, K0891.
2. A skin protection and/or positioning seat or back cushion that meets coverage criteria is provided.

If one of these criteria is not met, both the power wheelchair with a sling/solid seat and the general use cushion will be denied as not reasonable and necessary.

The face-to-face examination does not contain a date stamp (or equivalent) to document the receipt date of the documentation by 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.

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. If this requirement is not met, the claim will be denied as noncovered.

Education 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: https://www.noridianmedicare.com/dme/prior_authorization_demonstration_pmd. 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 Healthcare Common Procedure Coding System (HCPCS) codes that are eligible for the PAR demonstration.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Quarterly Results of Widespread Prepayment Review of Claims for Manual Wheelchairs (HCPCS K0001, K0003 and K0004)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code(s) K0001, K0003 and K0004. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The K0001 review involved 731 claims, of which 670 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.
- The K0003 review involved 382 claims, of which 373 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 93%.
- The K0004 review involved 230 claims, of which 215 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 91%.

Primary Documentation Errors that Resulted in Denial of Claims

- 23% of K0001 claims received a denial for an invalid or missing home assessment.
- 18% of K0003 claims received a denial for an invalid or missing home assessment.
- 15% of K0004 claims received a denial for an invalid or missing home assessment.

Documentation must support Criterion C: 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.

- 15% of K0001 claims received a denial regarding the resolution of the beneficiary's mobility limitations with a cane or walker.
- 13% of K0003 claims received a denial regarding the resolution of the beneficiary's mobility limitations with a cane or walker.
- 10% of K0004 claims received a denial regarding the resolution of the beneficiary's mobility limitations with a cane or walker.

The documentation must support Criterion B: The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

- 23% of K0003 claims received a denial as medical records do not support the beneficiary requires a lightweight wheelchair.

- 22% of K0004 claims received a denial as medical records do not support the beneficiary requires a high strength light weight wheelchair (K0004).

A lightweight wheelchair (K0003) is covered when the documentation supports that the beneficiary meets both criteria:

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

A high strength lightweight wheelchair (K0004) is covered when the documentation supports that the beneficiary meets criteria (1) or (2):

1. The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
2. 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.

- 11% of K0001 claims received a denial regarding the beneficiary's mobility limitation impairment to mobility-related activities of daily living (MRADLs).
- 9% of K0003 claims received a denial regarding the beneficiary's mobility limitation impairment to mobility-related activities of daily living (MRADLs).

Documentation provided must support Criterion A: The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing an MRADL entirely.
2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

- 12% of K0004 claims received a denial as the requested documentation was not received.

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.

- 8% of K0001 claims received a denial regarding manual wheelchair use significantly improving the beneficiary's ability to participate in MRADLs.

The documentation must support Criterion D: Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

- 8% of K0001 claims received a denial regarding insufficiency of upper extremity function and other physical and mental capabilities needed to safely self-propel the wheelchair.

The documentation must support Criterion F: The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Manual Wheelchair Bases Local Coverage Determination (LCD) L11454 and Policy Article A25378.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0822 and K0825)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0822 and K0825. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

The review of K0822 and K0825 claims involved 76 claims, of which 55 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

The documentation does not support the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.

LCD L23598 General Coverage Criterion C states, "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.

There was no detailed product description submitted or the detailed product description submitted was invalid.

Per LCD L23598, "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."

The face-to-face examination submitted was incomplete or missing elements.

LCD L23598 states, "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.

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.

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."

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.

Going Forward

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

Education 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 specific policy resources for Power Mobility Devices on the Noridian website at https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs and presentations used during Web-based workshops.

Noridian provides educational offerings by scheduling for supplier workshops, training opportunities and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train/index.html#tools.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Reminder: Manual Wheelchair Capacity Restrictions

In order to ensure Medicare payment, the manual wheelchair provided must have the most appropriate configuration and capacity as per Medicare rules, regulations and guidelines. Policy Article (PA) A25378 specifies the coding requirements for adult manual wheelchairs in regards to seat depth, width, wheel size and weight capacity. It is the supplier's responsibility to ensure that the item provided to the beneficiary meets the coding requirements as indicated.

Section II, appendix A, parts 1 and 2 of the Supplier Quality Standards requires that the supplier consult the prescribing physician as needed to confirm orders and recommend any necessary changes, refinements or additional evaluations to the prescribed equipment. The physician must also review the beneficiary's records as appropriate and incorporate any pertinent information related to the beneficiary's condition(s) which affects the provision of the DEMPOS equipment or related services.

Furthermore, the Supplier Manual Chapter 2, Supplier standard #4 states, "A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs."

Please remember that wheelchairs coded K0006 and K0007 are designed to meet weight capacities of 250 pounds or greater. Weight capacity is defined as the carrying capacity of the amount of weight (beneficiary plus all accessories) that the wheelchair can carry for safe operation.

Additionally, Local Coverage Determination (LCD) L11462 provides coding direction and requirements for nonstandard seat frame dimensions which may provide optimal configuration of manual wheelchairs.

Results of Widespread Prepayment Review Power Mobility Devices

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment review of billed power mobility devices when a change in medical need had been indicated. The edit effectiveness results from March 2013 through October 2013 are as follows:

The review involved 12 claims, of which 5 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 63%.

Primary Documentation Errors that Resulted in Denial of Claims

An incorrect modifier was used.

Per LCD L23598, modifiers to use for power mobility devices are:

EY – No physician or other licensed health care provider order for this item or service

GA – Waiver of liability statement issued as required by payer policy, individual case

GY – Item or service statutorily excluded or does not meet the definition of any Medicare benefit category

GZ – Item or service expected to be denied as not reasonable and necessary

KX – Requirements specified in the medical policy have been met

The face-to-face examination was incomplete or missing elements.

Per LCD L23598:

- 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 physician, who completes the 7-element order and the face-to-face examination, must be the same physician.

The documentation was illegible.

Per the article Illegible Documentation Guidelines:

Incomplete or illegible documentation can result in a denial of payment for services billed to Medicare. When documentation is faxed, it can often come in smudged or darkened, which makes that documentation illegible. Illegible documentation can include, but not limited to, documentation sent via fax or handwritten medical notes.

If medical documentation is unable to be faxed due to poor quality or readability, it can be mailed to:

Noridian
Attn: DME Redeterminations
PO Box 6727
Fargo ND 58108-6727

If the medical notes are handwritten and illegible, the appeal will remain denied as there is no medical documentation to review. If some of the medical documentation submitted is illegible, that documentation will be excluded and only the legible pieces will be considered as part of the appeals process.

Criterion C was not met.

The beneficiary's medical records did not support criterion C, as required per LCD L23598:

C. 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.

Going Forward

Noridian will close this widespread review.

Education 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 also need to be familiar with the Wheelchair Options/Accessories LCD L11462 and Policy Article A19846, and the Wheelchair Seating LCD L15670 and Policy Article A17265.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code J7605 and J7626. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from October 1, 2013, through December 31, 2013, resulted in an overall error rate of 39%.

Primary Documentation Errors that Resulted in Denial of Claims

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. The supplier standards can be found in 424 CFR Section 424.57(c).

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 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.

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).

The order submitted was invalid.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

Going Forward

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

Education Resources

The following references were used in the review of your claims and can be accessed on our Noridian website at https://www.noridianmedicare.com:

Nebulizers

- Local Coverage Determination L11488.
- Policy Article A24942.

In addition, the following references are educational resources related to the HCPCS code being reviewed:

- Documentation Checklists
  https://www.noridianmedicare.com/dme/coverage/docs/checklists/nebulizers_and_respiratory_drugs.html
- Physician Resource Letters
  https://www.noridianmedicare.com/dme/coverage/resources.html

Noridian provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf.

ORTHOTICS AND PROSTHETICS

Prefabricated Spinal Orthoses: L0631 & L0637 Coding Verification Requirement Reminder

Noridian Medical Review would like to remind manufacturers and suppliers about the coding verification requirements for prefabricated Spinal Orthoses.

Spinal Orthoses require coding verification review by the Pricing, Data Analysis and Coding (PDAC) contractor. As noted in the Local Coverage Article for Spinal Orthoses: TLSO and LSO -Policy Article (A23846), effective January 2013, the Healthcare Common Procedure Coding System (HCPCS) codes L0631 and L0637 will be denied if they are not listed on the PDAC Product Classification List.

Suppliers can check that the spinal orthosis being supplied meets the coding verification requirements by going to the PDAC website: https://www.dmepdac.com/dmecsapp/do/search. The following information should be entered under the section "Search DMEPOS Product Classification List":

- Manufacturer/Distributor.
- HCPCS code.

- Product Name.
- Product/Model.

If sufficient documentation is entered and Noridian has conducted a HCPCS coding verification review, search result will display the orthosis in question as well as its effective date.

When responding to a documentation request, documentation to support that the coding verification requirements have been met must be included.

The Coding Guidelines section of the Policy Article A23846 states:

> *Effective for claims with dates of service on or after July 1, 2010, the only products that may be billed using codes, L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637, and L0639 for prefabricated orthoses are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site.*
>
> *Effective for claims with dates of service on or after July 1, 2010, prefabricated spinal orthoses and spinal orthoses that are custom fabricated by a manufacturer/central fabrication facility which has not received coding verification review from the PDAC must be billed with code A9270.*

Suppliers should contact the PDAC for guidance on the correct coding of these items. Coding decisions are updated frequently. Suppliers should refer to the Product Classification List often to ensure Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items billed have been coded by the PDAC. The Product Classification List is located on Durable Medical Equipment Coding System (DMECS) which is located on the PDAC website at: https://www.dmepdac.com/dmecs/index.html.

Refer to the complete Local Coverage Determination (L11459) and Policy Article (A23846) for additional information.

Quarterly Results of Widespread Prepayment Review of Claims for Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1970, L1960 and L4360

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L1970, L1960 and L4360. The quarterly edit effectiveness results from September 2013 through December 2013 are as follows:

- The L1970 review involved 424 claims, of which 379 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.
- The L1960 review involved 273 claims, of which 244 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.
- The L4360 review involved 1,797 claims, of which 1,538 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 86 %.

Primary Documentation Errors that Resulted in Denial of Claims

The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis. For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support medical necessity of custom-fabricated rather than a prefabricated orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

Documentation submitted was insufficient to support custom coverage criteria. AFO's and KAFO's that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

1. The beneficiary could not be fit with a prefabricated AFO.
2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months).
3. There is a need to control the knee, ankle or foot in more than one plane.

4. The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury.
5. The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions.

If a custom-fabricated orthosis is provided but basic coverage criteria and the additional criteria 1-5 for a custom-fabricated orthosis are not met, the custom-fabricated orthosis will be denied as not reasonable and necessary.

Documentation submitted was insufficient to support basic coverage criteria. Ankle-foot orthoses (AFO) described by codes L1900, L1902–L1990, L2106–L2116, L4350, L4360, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

There was no detailed written order or dispensing order provided. All items billed to Medicare require a prescription. An order for each new or full replacement item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. 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 items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim. 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 start date, if start date different than date of order.
- Detailed description of the item(s).
- Physician signature and signature date.

Going Forward

Based on the high error rate, Noridian will continue with the Prepayment Widespread Review.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Ankle-Foot/Ankle-Knee-Foot Orthosis Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review a specific policy Documentation Checklist for Ankle-Foot/Ankle-Knee-Foot Orthosis on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for External Breast Prostheses (HCPCS L8030)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code L8030. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The L8030 review involved 558 claims, of which 335 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 57%.

Primary Documentation Errors that Resulted in Denial of Claims

- 14% of L8030 claims received a denial as no documentation was received.

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 Section 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.

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.

- 11% of L8030 claims received a denial as no office notes or medical records to support medical necessity were submitted.

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.

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.

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.

- 7% of L8030 claims received a denial as the order was incomplete or missing elements.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

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

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

The DWO must be available upon request.

- 7% of L8030 claims received a denial as documentation did not support continued need.

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial 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:

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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the External Breast Prostheses Local Coverage Determination (LCD) L11569 and Policy Article A19833.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Lower Limb Prostheses (HCPCS L5981)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code L5981. The quarterly edit effectiveness results from September 2013 through December 2013 are as follows:

- The L5981 review involved 12 claims, of which 12 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

Primary Documentation Errors that Resulted in Denial of Claims

Documentation does not support medical need for replacement item. 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.

Records submitted are from a prosthetist/orthotist, documentation was not submitted from physician. 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 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.

Invalid proof of delivery was 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), 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.

Going Forward

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

Education 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.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Results of Widespread Prepayment Probe Review of Lower Limb Prostheses (HCPCS L5987)

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes L5987. This review was initiated based on results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

- The L5987 review involved 99 claims, of which 81 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.

Primary Documentation Errors that Resulted in Denial of Claims

Documentation does not support the functional level billed on the claim. A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to: 1. The beneficiary's past history (including prior prosthetic use if applicable); and 2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and 3. The beneficiary's desire to ambulate.

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

Documentation does not support medical need for replacement. Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following: 1. A change in the physiological condition of the beneficiary; or 2. Irreparable wear of the device or a part of the device; or 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time.

A lower limb prosthesis is covered when the beneficiary:

1. Will reach or maintain a defined functional state within a reasonable period of time.
2. Is motivated to ambulate.

Requested documentation was not received by the contractor within the allotted timeframe. Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS code L5987.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prosthesis Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Spinal Orthoses: LSO (HCPCS L0631 and L0637)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L0631and L0637. The quarterly edit effectiveness results from October 2013 through December 2013 are as follows:

- The L0631 review involved 1,247 claims, of which 1,092 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 88%.
- The L0637 review involved 757 claims, of which 628 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 83%.

Primary Documentation Errors that Resulted in Denial of Claims

- 18% of L0631 claims received a denial as coverage criteria indicated in Spinal Orthoses LCD (L11459) was not met.
- 16% of L0637 claims received a denial as coverage criteria indicated in Spinal Orthoses LCD (L11459) was not met.

A thoracic-lumbar-sacral orthosis (L0450-L0492), lumbar orthosis (L0625-L0627) or lumbar-sacral orthosis (L0628-L0640) is covered when it is ordered for one of the following indications:

1. To reduce pain by restricting mobility of the trunk.
2. To facilitate healing following an injury to the spine or related soft tissues.
3. To facilitate healing following a surgical procedure on the spine or related soft tissue.
4. To otherwise support weak spinal muscles and/or a deformed spine.

- 18% of L0631 claims received a denial as the proof of delivery provided was invalid.
- 15% of L0637 claims received a denial as the proof of delivery provided was invalid.

Proof of Delivery (PIM 4.26, 5.8)

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 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.

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.

- 17% of L0631 claims received a denial as the DME item does not have the required coding verification or unable to verify the DME item as being listed on the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor website.
- 13% of L0637 claims received a denial as the DME item does not have the required coding verification or unable to verify the DME item as being listed on the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor website.

Manufacturers and suppliers are reminded that a number of items require coding verification review by the Pricing, Data Analysis and Coding (PDAC) contractor. As noted in the Local Coverage Determinations (LCD) and related Policy Articles that include these codes, claims for these Healthcare Common Procedure Coding System (HCPCS) codes will be denied if the products requiring coding verification review are not listed on the PDAC Product Classification List. Coding decisions are updated frequently. Suppliers should refer to the Product Classification List often to ensure Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items billed have been coded by the PDAC. The Product Classification List is located on Durable Medical Equipment Coding System (DMECS) which is located on the PDAC website at: https://www.dmepdac.com/dmecs/index.html.

Effective for claims with dates of service on or after July 1, 2010, the only products that may be billed using codes, L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637, and L0639 for prefabricated orthoses are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor website.

Effective for claims with dates of service on or after July 1, 2010, prefabricated spinal orthoses and spinal orthoses that are custom fabricated by a manufacturer/central fabrication facility which have not received coding verification review from the PDAC must be billed with code A9270.

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

- 13.5% of L0631 claims received a denial as no documentation was received in response to the additional documentation request.
- 18% of L0637 claims received a denial as no documentation was received in response to the additional documentation request.

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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses Local Coverage Determination LCD 11459 and Policy Article A23846.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Breathe NIOV™ – Coding Reminder – Revised January 2014

Joint DME MAC Publication

This article updates and replaces the previous version published in December 2012.

The Non-invasive OPEN Ventilation System (NIOV™) by Breathe Technologies, Inc. provides positive pressure inspiratory support for patients using oxygen. This product consists of multiple components – control unit, flow regulator, connecting hose and nasal interface (pillows). E1352 is an all-inclusive code for this product that includes all components. For the BREATHE NON INVASIVE OPEN VENTILATION (NIOV) SYSTEM, the HCPCS code listed below should be used when billing the DME MACs:

E1352 OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE.

If pillows and hoses are billed separately for replacement purposes use:

A9900 (MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE)

Based on clinical data provided by the manufacturer, this item is effective only when used in conjunction with oxygen; therefore, it is classified as an accessory to oxygen equipment. E1352 is not eligible for separate billing as stand-alone DME under this classification.

Oxygen reimbursement is a bundled payment. All options, supplies and accessories are considered included in the monthly rental payment for oxygen equipment. Oxygen rental is billed using the appropriate code for the provided oxygen equipment. Separately billed options, accessories or supply items will be denied as unbundling.

Note: Numerous sources, including the manufacturer's materials and references in published clinical articles, use the term "ventilator" when discussing this device. For Medicare payment purposes, the NIOV™ device is **not** considered a ventilator or any other type of positive airway pressure device (CPAP, bi-level PAP, etc.). DMEPOS suppliers must not use HCPCS codes assigned to those products when submitting claims for the NIOV™ device.

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination and related Policy Article for additional information about documentation, coverage and coding requirements.

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

Correct Coding – Supplies Used With E0446 – Joint DME MAC Publication

E0446 (TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES) as described in the narrative is all-inclusive. There is no separate reimbursement for any supplies used with this item. This includes items such as tape, dressings,tubing, etc.

If the supplies are billed separately, HCPCS code A9900 (MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE) must be used.

Claims for supplies used with E0446 will be denied as unbundling.

Claims for E0446 and related items will be denied as not reasonable and necessary (National Coverage Determinations 20.29.C & 270.5).

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

Frequently Asked Questions: Oxygen Use in Beneficiaries with Obstructive Sleep Apnea

Medicare does not provide reimbursement for home oxygen as a treatment of Obstructive Sleep Apnea (OSA). However many beneficiaries with OSA have co-existing chronic pulmonary conditions that would justify coverage of home oxygen, after appropriate titration polysomnogram (PSG) and meeting the requirements specified in the Oxygen LCD. Both the Oxygen LCD and the Positive Airway Pressure Devices (PAP) LCD contain detailed information about the testing necessary to justify payment of home oxygen. This FAQ discusses some of the common scenarios seen. Refer to the LCDs for detailed information about coverage of PAP and home oxygen.

Following the Q&A, an algorithm is included to assist in analyzing OSA / home oxygen testing scenarios. Note that the algorithm does not itemize all coverage requirements for OSA or home oxygen. It is intended as an overview of qualification testing. Refer to the LCDs for detailed information about payment rules.

1. A beneficiary has a diagnosis of obstructive sleep apnea (OSA) and does not meet any of the Oxygen LCD Group I or Group II criteria, yet their physician has prescribed home oxygen therapy. In this instance, would the home oxygen be covered?

   Response: No, home oxygen would not be covered. In order for home oxygen to be reimbursed the payment rules described in the oxygen policy must be met.

2. A beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration polysomnogram (PSG) as described in the oxygen LCD. Following diagnosis and optimal treatment of the OSA during the titration PSG, it is discovered that the beneficiary is not using the PAP device as prescribed (refused the device, is non-compliant, etc.) but the physician has prescribed oxygen for use during sleep.In this instance, would the home oxygen be covered?

   Response: Yes, home oxygen is covered. For beneficiaries with OSA, the titration PSG is used to:

   - Assure that the OSA is optimally treated thus satisfying the Oxygen LCD "chronic stable state" requirement.
   - Determine that the remaining hypoxia meets the Oxygen LCD qualification threshold.

   Beneficiary compliance with treatment after testing is not a factor in determining eligibility for payment of home oxygen.

   Note: This answer assumes that OSA is the only other concurrent condition that could affect blood oxygen levels and that the underlying lung disease is adequately treated and stable as required by the Oxygen LCD.

3. A beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration polysomnogram (PSG) as described in the oxygen LCD; however, the beneficiary is unable to tolerate PAP therapy during the titration PSG. The physician does not prescribe PAP but rather prescribes oxygen therapy. In this instance, would the home oxygen be covered?

   Response: No, home oxygen is not covered. Oxygen is not the primary treatment for OSA. The Oxygen LCD requires that the beneficiary is optimally treated with respect to their OSA thus satisfying the Oxygen LCD "chronic stable state" requirement.

4. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary has tried PAP, other treatment options, such as an oral appliance, weight loss and surgery. All treatments have been determined by their physician to be unsuccessful. With no active OSA treatment, the beneficiary continues to desaturate at night (< 88% for 5 total minutes or more), as evidenced by overnight oximetry testing. The physician has prescribed home oxygen for use at night. In this instance, would the home oxygen be covered?

Response: This question actually has insufficient information to determine whether home oxygen might be eligible for payment. What is missing is information about the type of testing done. A titration PSG must have been performed. During the titration phase, optimal treatment with the PAP device must have been achieved. Only after optimal treatment with a PAP device can an assessment of the remaining hypoxia (if any) be done. For the beneficiaries remaining hypoxic while receiving optimal PAP therapy, home oxygen may be covered if the oxygen testing reaches the levels required by the oxygen LCD. Compliance with treatment for OSA is not a determining factor for qualification of home oxygen.

5. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). During a titration PSG that lasted more than 2 hours, the beneficiary was titrated with PAP to an AHI/RDI of <10 events per hour, yet continued to desaturate below 88% for more than five total minutes. The physician has prescribed oxygen for use in conjunction with the PAP. In this instance, would the home oxygen be covered?

   Response: Yes, home oxygen would be covered. The question restates the titration PSG requirements described in the LCDs. A titration PSG meeting these requirements can be used for qualification of home oxygen.

6. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary was prescribed a PAP and the physician has ordered a home overnight oximetry test that was performed on room air without the beneficiary using their PAP device. The beneficiary desaturated below 88% for more than five total minutes. In this instance, would the home oxygen be covered?

   Response: No, home oxygen would not be covered. Beneficiaries with diagnosed but untreated OSA are not in a "chronic, stable state". Therefore, they do not meet the Oxygen LCD Group I or Group II criteria. Only testing with a titration PSG may be used to qualify a beneficiary with OSA for concurrent payment of home oxygen.

7. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary was prescribed a PAP and the physician has ordered a home overnight oximetry test that was performed on room air with the beneficiary using their PAP device. The beneficiary desaturated below 88% for more than five total minutes. In this instance, would the home oxygen be covered?

   Response: No, home oxygen would not be covered. Only testing with a titration PSG may be used to qualify a beneficiary with OSA for concurrent payment of home oxygen.

8. A beneficiary has diagnoses of OSA and chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary has an oximetry testing performed during the day, while at rest. The beneficiary's resting SpO2 is < 88% and the beneficiary's physician has prescribed home oxygen therapy. In this instance, would home oxygen be covered?

   Response: Yes, home oxygen would be covered. This beneficiary meets the Oxygen LCD Group I criteria. Oximetry testing while the beneficiary is awake may be used for qualification of home oxygen. While awake OSA does not affect blood oxygen levels.

9. A beneficiary has diagnoses of OSA and chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary has pulse oximetry testing performed during the day, while exercising. The beneficiary's baseline SpO2 is 92% and their SpO2 < 88% during exercise. The beneficiary is tested during exercise while on oxygen and their SpO2 is 92%. The physician prescribes home oxygen therapy for use during activity/exercise. In this instance, would home oxygen be covered?

   Response: Yes, home oxygen would be covered. This beneficiary meets the Oxygen LCD Group I criteria. As discussed in Q7, oximetry testing while awake continues to be acceptable for the qualification of home oxygen. OSA does not affect the blood oxygen levels of an awake beneficiary.

10. When oxygen qualification testing is obtained from a titration polysomnogram, is portable oxygen covered?

    Response: No, as with overnight oximetry, only stationary oxygen is justified based on titration polysomnography.

11. For a beneficiary now eligible for Medicare who is already on PAP and O2, are both therapies eligible for reimbursement?

    Response: Each therapy has separate and independent coverage criteria that must be met in order to be eligible for Medicare reimbursement. Items reimbursed by other payers prior to Medicare eligibility are not a determinant for Medicare program payment. Claims submitted to Medicare for items previously paid outside of Medicare are considered new, initial Medicare claims. All applicable coverage and documentation requirements in effect at the initial Medicare DOS must be met. There are two limited exceptions:

    - For PAP:
      - The original testing done to diagnose OSA may be used to qualify for Medicare coverage if the results meet or exceed Medicare AHI/RDI requirements; and,
      - The 90-day compliance period is replaced with an in-person physician visit that documents (1) compliant use of the equipment and (2) benefit from therapy.
    - For Home Oxygen:
    - For beneficiaries who start oxygen while enrolled in a Medicare managed care plan, the blood oxygen testing used by the plan for qualification may be used for qualification purposes by fee-for-service Medicare.

Refer to the relevant LCD and related Policy Article for details about coverage and documentation requirements.

Quarterly Results of Documentation Compliance Review of Claims for Oxygen (HCPCS E1390)

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code E1390, oxygen concentrator. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from September 1, 2013 through November 30, 2013, resulted in an overall error rate of 32%.

Primary Documentation Errors that Resulted in Denial of Claims

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:

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.)

Requested documentation was not received by the contractor within the allotted timeframe. Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

There was no proof of delivery (POD) submitted or the POD was invalid.

Proof of Delivery

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:

- 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 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.

Going Forward

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

Education Resources

The following references were used in the review of your claims and can be accessed on our Noridian website at https://www.noridianmedicare.com:

Oxygen and Oxygen Equipment

- Local Coverage Determination L11457.
- Policy Article A33677.
- National Coverage Determination 240.2.
- Consolidated Resources – Oxygen and Oxygen Equipment.

In addition, the following references are educational resources related to the HCPCS code being reviewed:

- Documentation Checklists https://www.noridianmedicare.com/dme/coverage/checklists.html.
- Physician Resource Letters https://www.noridianmedicare.com/dme/coverage/resources.html
- CMN Form https://www.noridianmedicare.com/dme/forms/cmn_dif_forms.html
- Policy Specific Training/Events https://www.noridianmedicare.com/dme/train/

Noridian provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS E0439 and E0434)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0439 and E0434. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The E0439 review involved 328 claims, of which 221 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 66%.
- The E0434 review involved 147 claims, of which 122 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 68%.

Primary Documentation Errors that Resulted in Denial of Claims

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 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..

No documentation was received in response to the Additional Documentation Request (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. The supplier standards can be found in 424 CFR Section 424.57(c).

The date of the physician's signature on the CMN/order is after the date of service on the claim and a verbal/dispensing order was not provided. 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.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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.

5.2.3.2.3 – Detailed Written Order for Covered Items

(Rev. 468; Issued: 05-31-13; Effective: 07-01-13; Implementation: 07-01-13)

For a covered DME item, outlined in 42 CFR 410.38(g), the contractor shall ensure that the detailed written order is consistent with PIM Chapter 5 § 5.2.3. Consistent with 42 CFR 410.38(g) the order must include, at a minimum;

- The beneficiary's name.
- The item of DME ordered.
- The prescribing practitioner's NPI.
- The signature of the ordering practitioner (physician, PA, NP, or CNS) and the date of the order.

If this information is not included on the detailed written order, the claim will be denied. Medicare requires that the detailed written order is completed after the face-to-face encounter. If the date of the detailed written order is prior to the date of the face-to-face encounter, the contractor shall deny the claim.

The submitted blood gas study obtained during exercise is invalid.

Exercise testing: When oxygen is covered based on an oximetry study obtained during exercise, there must be documentation of three (3) oximetry studies in the beneficiary's medical record. (1) Testing at rest without oxygen, (2) testing during exercise without oxygen, and (3) testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia) are required. All 3 tests must be performed within the same testing session. Exercise testing must be performed in-person by a physician or other medical professional qualified to conduct exercise oximetry testing. Unsupervised or remotely supervised home exercise testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment. Only the testing during exercise without oxygen is used for qualification and reported on the CMN. The other two results do not have to be routinely submitted but must be available on request.

Oximetry obtained after exercise while resting, sometimes referred to as "recovery" testing, is not part of the three required test elements and is not valid for determining eligibility for oxygen coverage

Going Forward

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

Education 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.

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/oxygen_and_oxygen_equipment.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Revised: Payment Rules Reminder – Home Oxygen Initial Qualification Testing

Joint DME MAC Publication

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when the beneficiary meets all of the requirements set out in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) and related Policy Article (PA). This article reviews the blood oxygen testing requirements. Refer to the LCD and PA for information on additional payment criteria.

Qualifying Test Results

The results of a blood gas study that has been ordered and evaluated by the attending physician are used as one of the criteria for determining Medicare reimbursement.

Medicare classifies qualification results into three groups, regardless of the test methodology used. The following table summarizes the qualifying results for each group.

	ABG (mm HG)	Oximetry (% Sat)	Notes
Group 1	≤55	≤88	-
Group 2	56-59	89	+ Additional disease criteria
Group 3	>59	>89	Presumed noncovered

Qualification Tests

Blood oxygen levels are used to assess the beneficiary's degree of hypoxemia. Blood oxygen levels may be determined by either of two different test methods:

- Arterial blood gas (ABG) measurement.
- Pulse oximetry.

Arterial blood gas measurements are more accurate and therefore are the preferred measurement method. When both ABGs and oximetry are performed on the same day, the ABG value must be used for reimbursement qualification.

Pulse oximetry values may be obtained using a variety of techniques. The LCD describes the following as acceptable oximetry testing methods:

- At rest and awake - often referred to as "spot" oximetry.

- During exercise – requires a series of 3 tests done during a single testing session:
  - At rest, off oxygen - showing a non-qualifying result.
  - Exercising, off oxygen – showing a qualifying result.
  - Exercising, on oxygen – showing improvement in test results obtained while exercising off of oxygen.
- During sleep.
  - Overnight sleep oximetry.
- May be done in hospital or at home. Refer to the LCD for detailed information about home overnight sleep oximetry.
  - Titration Polysomnogram.
- Must be used for beneficiaries with concurrent (OSA) in order to establish that the beneficiary is in the "chronic stable state".
- Refer to the Positive Airway Pressure Devices LCD for information about testing for OSA.

Note: The overnight sleep oximetry and the titration polysomnogram referenced above are not the same test as home sleep testing used for the diagnosis of Obstructive Sleep Apnea.

Chronic Stable State (CSS)

All qualification testing must be performed while the beneficiary is in the CSS. CSS requires that all of the following be met:

- [O]ther forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required.
- Each patient must receive optimum therapy before long-term home oxygen therapy is ordered.
- It is expected that virtually all patients who qualify for home oxygen coverage for the first time under these guidelines have recently been discharged from a hospital where they submitted to arterial blood gas tests… If more than one arterial blood gas test is performed during the patient's hospital stay, the test result obtained closest to, but no earlier than two days prior to the hospital discharge date is required as evidence of the need for home oxygen therapy. (**Note:** This is the only exception to the CSS requirement).

For those patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state, i.e., not during a period of an acute illness or an exacerbation of their underlying disease.

Qualified Testing Providers

Oxygen qualification testing may only be performed by providers designated as qualified to perform such testing. Testing done by non-qualified entities is not valid for purposes of qualification for Medicare reimbursement for home oxygen. The LCD states:

> *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.*

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.

For purposes of meeting the "qualified provider" criterion, this policy uses a determination based upon two criteria:

1. Whether the test performed meets the applicable requirements for Medicare billing of the specific test.
2. The entity that performed the test meets the applicable requirements for Medicare billing of the specific test.

Note: This does not require that the specific test be actually billed and/or paid, only that the testing entity meet the requirements necessary to perform and bill Medicare for the actual test. The following describes payment scenarios:

- Under Medicare Part A.
  - During a Part A covered stay payment is bundled such that services rendered are covered under a lump sum payment by Medicare. In this case, oxygen qualification testing performed in a hospital, nursing facility, Home Health or Hospice or other covered Part A episode meets the "qualified provider" standard.
  - Outside of a covered Part A stay, testing done by a Part A provider does not meet the requirement and is not valid for qualification of home oxygen reimbursement unless the entity is also a qualified provider of diagnostic testing or laboratory services for individual testing performed outside of a covered Part A stay.
- Under Medicare Part B
  - Testing performed and covered as "incident to" physician services meets the "qualified provider" standard.
  - Laboratory testing is also reimbursed "a la carte" or on a per test basis. The entity performing the specific test must meet the requirements to perform the specific test. Testing done by an entity that meets the requirements to bill for the individual test meets may be used for oxygen qualification.

Timing of Testing

For initial qualification testing scenarios, the qualification testing must be performed within the 30 days before the initial date of certification (prescription date).

As described earlier, for oxygen initially prescribed at the time of hospital discharge, testing must be performed within the 2 days prior to discharge. This 2-day prior to discharge rule does not apply to discharges from nursing facilities.

Refer to the Local Coverage Determination, related Policy Article and the DME MAC Supplier Manual for additional information concerning the payment rules for reimbursement of oxygen and oxygen equipment.

Supplier "Abandonment" of Beneficiaries and Oxygen Equipment

Recently the Centers for Medicare & Medicaid Services (CMS) issued instructions to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to process claims for replacement oxygen and oxygen equipment in the event that a supplier voluntarily exits the Medicare oxygen business (for example, goes out of business) and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and non-competitive bid areas.

In these situations, CMS considers the equipment "lost" under the Medicare regulations at 42 CFR §414.210(f), which provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen or irreparably damaged. When considering "lost" equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier furnishing replacement oxygen and oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

Obligations of Exiting Supplier

Suppliers voluntarily exiting the Medicare program are reminded that they are in violation of their regulatory and statutory obligations. Section 1834(a)(5)(F)(ii)(I) requires that the supplier that received the 36th month rental payment continue furnishing the oxygen equipment during any period of medical need for the reminder of the equipment's reasonable useful lifetime. Further, 42 CFR 414.226(g)(1) requires, barring a few exceptions, that the supplier that furnishes oxygen equipment in the first month during which payment is made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends. As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier standards set forth at 42 CFR 424.535(c). Violations of the supplier standards are reported to the National Supplier Clearinghouse.

Suppliers voluntarily exiting the program must provide a ninety (90) day notice to the beneficiary of their intention to no longer provide oxygen therapy services. This must be provided in writing and must take one of two forms:

1. A letter to the beneficiary notifying them of the supplier's intention to discontinue oxygen therapy services. The letter must specify a date upon which this will occur.
2. Working with the beneficiary, a letter to a new supplier selected by the beneficiary, transferring provision of oxygen therapy services to the new supplier as of a specific date.

Obligations of New Supplier

For suppliers who receive beneficiaries from providers who have elected to voluntarily exit the Medicare oxygen business, claims for replacement equipment must:

1. Include the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment.
2. Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.

In addition to providing the above information on the replacement equipment claim, in the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement are either:

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier's services were being terminated.
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program.

If the new supplier is unable to obtain the documentation required above, the supplier may not append the RA modifier to the claim and may not initiate a new 36-month capped rental period.

Suppliers accepting transfer of beneficiaries are reminded that all Medicare rules apply. This includes obtaining:

1. New order.
2. New initial Certificate of Medical Necessity (CMN).
    - Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
    - There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.
3. Medical necessity documentation as outlined in the Oxygen LCD.

Suppliers should review the entire Oxygen LCD and Policy Article for additional information on coding, coverage and documentation requirements.

Correct Coding – Liners Used with PAP Mask

A liner is a device which is placed between the patient's skin and the Positive Airway Pressure (PAP) mask interface. Liners used with a PAP mask are made of cloth, silicone or other materials. A liner used in conjunction with a PAP mask is considered comfort/convenience item.

There is no additional payment for liners used with a PAP mask. These products should be coded A9270 (Noncovered item or service) in accordance with the Medicare Benefit Policy Manual 100-2 Chapter 15 Section 110.1.

Liners are not interfaces for use with a PAP mask. Consequently, liners should not be billed as replacement features of a PAP mask such as A7031 (Face mask interface, replacement for full face mask, each) or A7032 (Cushion for use on nasal mask interface, replacement only, each).

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

Quarterly Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Devices (HCPCS E0601)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0601 for the first month of billing (KH modifier) and the 4th-13th month of billing (KJ modifier). The sixth quarterly edit effectiveness results for KH modifier from July 2013 to October 2013 and for KJ modifier from August 2013 to November 2013 are as follows:

- The E0601KH review involved 3139 claims, of which 1715 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 53%.
- The E0601KJ review involved 1941 claims, of which 1119 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 60%.

Primary Documentation Errors that Resulted in Denial of Claims

No documentation was received. A large number of suppliers failed to respond to our request for records. 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 a referral to the NSC.

Documentation did not support Criteria A (face-to-face clinical evaluation) was met. The patient must have a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea. (Criteria A of LCD L171)

Documentation did not support criterion one (Face-to-face clinical re-evaluation) 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:

- Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved.

Documentation did not support criterion two (objective evidence of adherence to use of the PAP device, reviewed by the treating physician) 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.

PAP DEVICES

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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination (LCD) L171 and Policy Article A19827.

Suppliers can also review specific policy resources for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/pap_devices.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train/.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

PECOS

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

MLN Matters® Number: SE1305 Revised

Related Change Request (CR) #: 6421, 6417, 6696, 6856

This article was revised on February 6, 2014, to modify the answer to question on J on page 10 (underlined). The article was previously changed on November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the Advance Beneficiary Notice, CARC codes and DME rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same.

Note: This article was previously revised on April 19, 2013, to add references to the CMS-1450 form and to add question H. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

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

Provider Action Needed

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

What Providers Need to Know

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

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

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

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

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

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI).

The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

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

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

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

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

CMS would like to highlight the following limitations:

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

Questions and Answers Relating to the Edits

1. **What are the ordering and referring edits?**
   The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).
2. **Why did Medicare implement these edits?**
   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.
3. **How and when will these edits be implemented?**
   These edits were implemented in two phases:

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

For Part B providers and suppliers who submit claims to carriers:	
N264	Missing/incomplete/invalid ordering provider name
N265	Missing/incomplete/invalid ordering provider primary identifier

For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):	
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:	
N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.1

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html; click on "Ordering & Referring Information" (on the left). Information about the Report will be displayed.

[1] NPIs were added only when the matching criteria verified the NPI.

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

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

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

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

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

Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?
In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

1. **You have a current Medicare enrollment record.**
   - If you are not sure you are enrolled in Medicare, you may:
     - Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI.
     - Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI.
     - Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
     - If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
2. **If you do not have an enrollment record in Medicare.**
   - You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
     - For paper applications – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
     - For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.

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

3. **You are an opt-out physician and would like to order and refer services. What should you do?**
4. If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).
5. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.**

   When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.
6. **I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?**
   - You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.
   - Ensure you are correctly spelling the Ordering/Referring Provider's name.
   - If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits.
   - The Ordering Referring Report will be replaced weekly to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report.
7. **Make sure your claims are properly completed.**
   - On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the Ordering and Referring file found on CMS.gov.
   - On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
   - On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the Ordering/Referring name field, as their use could cause the claim to fail the edits.
   - Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the

physician or non-physician practitioner who generated the order or referral.

- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

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

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

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

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

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

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

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

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

11. **A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?**

    Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional Guidance

1. **Terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

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

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

Additional Article Updates

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

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

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

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

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

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

Dear Physician Letter – PECOS

December 2013

Dear Physician:

The Centers for Medicare and Medicaid Services (CMS) is expanding claim edits for ordering/referring providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Effective January 6, 2014, implementation of specific edits will occur that will restrict DMEPOS suppliers from receiving payment from Medicare for items that you have prescribed if you do not have a current enrollment in the Medicare Provider Enrollment, Chain and Ownership System (PECOS). Help your DMEPOS supplier to continue providing quality services to your Medicare patients by promptly enrolling in PECOS, or by updating your existing Medicare enrollment information if you have not done so recently.

For any DMEPOS item to qualify for coverage by Medicare it must be ordered by a physician or a practitioner who is eligible to order such item. To be eligible:

- Physicians or practitioners must be enrolled in PECOS.
- Must be registered in the system.
- Have a specialty that is eligible to order DMEPOS items for Medicare beneficiaries.

The provider specialties who can order DMEPOS items include:

- Doctor of Medicine or Osteopathy.
- Doctor of Dental Medicine or Dental Surgery.
- Doctor of Podiatric Medicine.
- Physician Assistant.
- Certified Clinical Nurse Specialist.
- Nurse Practitioner.
- Doctor of Optometry.

In order to continue to order DMEPOS for Medicare beneficiaries, you will have to enroll in the Medicare program or "revalidate" your Medicare enrollment information. You may do so by:

- Using Internet-based PECOS.
- By filling out the appropriate Medicare provider enrollment application(s) and mailing it, along with any required information, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application.

To confirm if you have a current enrollment record in Medicare, contact your designated enrollment contractor or you can go on-line, using Internet-based PECOS, to view your enrollment record. While doing so, if you have a PECOS record, ensure that your NPI is in it. If it is not, update your enrollment record.

For additional information consult with your Local A/B Medicare Administrative Contractor.

Sincerely,

Paul J. Hughes, M.D. Medical Director, DME MAC, Jurisdiction A NHIC, Corp.	**Robert D. Hoover, Jr., MD, MPH, FACP** Medical Director, DME MAC, Jurisdiction C CGS Administrators, LLC
Stacey V. Brennan, M.D., FAAFP Medical Director, DME MAC, Jurisdiction B National Government Services	**Eileen M. Moynihan, MD, FACP, FACR** Medical Director, DME MAC, Jurisdiction D Noridian Healthcare Solutions

IVR Changes for Provider Enrollment

On Thursday, January 30, 2014, the Noridian Jurisdiction D IVR's Provider Enrollment Menu option was updated to better assist suppliers in researching and avoiding referring physician denials. As a result of these updates, suppliers will need to have additional information ready when using the IVR. Please see below for updated instructions on using the Provider Enrollment menu option and a summary of the information which is available.

Main Menu Option 6 - Provider Enrollment

The IVR will collect the following information:

- Referring Physician NPI.
- Referring Physician Name (First and Last).
- Date of Service (the date the equipment was or will be provided).

After collecting the information the IVR will return one of the following. Keep in mind the response is specific to the referring physician's enrollment status for the date of service provided.

- NPI not found – The referring physician is not currently able to refer Medicare services. Please confirm the referring physician NPI you gave me is correct. If you have confirmed this information is correct, contact the referring physician for status information.
- Active for the date of service – The referring physician is currently enrolled in the Medicare program and is active.
- Inactive for the date of service – The referring physician is enrolled in the Medicare program but is not active. Please contact the referring physician for status information.
- Not Enrolled – The referring physician is currently not enrolled in the Medicare program. Please contact the referring physician for status information.

If the NPI and name entered have been verified and found to be correct but the IVR is not returning the results expected, contact the referring physician for assistance. The referring physician may need to contact his/her provider enrollment office.

Quarterly Results of Widespread Prepayment Review of Claims for Group 2 Pressure Reducing Support Surfaces (HCPCS E0277)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPC code E0277. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

- The E0277 review involved 233 claims, of which 190 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 81%.

Primary Documentation Errors that Resulted in Denial of Claims

Medical records submitted 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):

1. 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.
    - Regular assessment by a nurse, physician, or other licensed healthcare practitioner.
    - Appropriate turning and positioning.
    - Appropriate wound care.
    - Appropriate management of moisture/incontinence.

- Nutritional assessment and intervention consistent with the overall plan of care.

2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02-707.05).
3. 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 Additional Documentation Letters (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 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.

Proof of delivery was signed and dated after date of service on claim. 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.

Exceptions to the preceding statement concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility. A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and use the place of service (POS) as 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Documentation did not include staging of pressure ulcer. 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 muscle 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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) L11579 and Policy Article A35422.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

REFILLS

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.

REPAIRS

Reminder Supplier Standard #6 – Repairs and Labor Covered by Warranty

DMEPOS supplier standard #6 states: "A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty."

Medicare allows for the repair of beneficiary-owned equipment if the beneficiary meets Medicare's current coverage and documentation requirements as specified in the medical policies. Medicare will consider repairs when necessary to make the equipment serviceable or when non-routine maintenance is performed by authorized technicians, per manufacturer recommendations.

Medicare pays for reasonable and necessary labor and parts not otherwise covered under a manufacturer's or supplier's warranty. Unless a warranty specifically excludes an item from the warranty, neither the beneficiary nor the Medicare program may be charged.

Related Content

- DMEPOS Supplier Standards.
- Jurisdiction D DME MAC Supplier Manual.
- DME on Demand: Repairs and Replacements.

2014 Update for DMEPOS Fee Schedule

MLN Matters® Number: MM8531 Revised
Related Change Request (CR) #: CR 8531
Related CR Release Date: December 13, 2013
Related CR Transmittal #: R2836CP
Effective Date: January 1, 2014
Implementation January 6, 2014

Note: This article was revised on March 6, 2014, to provide updates regarding HCPCS code changes that were effective January 1, 2014. The changes are on page 2 (bold). All other information remains unchanged.

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8531 to advise providers of the Calendar Year (CY) 2014 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 DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and Key Points of CR8531

The DMEPOS fee schedules are updated 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 Section1834 (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) and splints, casts, and certain intraocular lenses.

Fee Schedule Files

The DMEPOS fee schedule file will also 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, 2014;

- A7047 in the inexpensive/routinely purchased (IN) payment category.
- E0766 in the frequently serviced (FS) payment category; and E1352.

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430.

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

For gap filling purposes, the 2013 deflation factors by payment category are listed in the following table: Factor	Category
0.469	Oxygen
0.472	Capped Rental
0.473	Prosthetics and Orthotics
0.600	Surgical Dressings
0.653	Parental and Enteral Nutrition

Specific Coding and Pricing Issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each.
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each.

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. 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 CY2004. For 2014, 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 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-Shelf Orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing Off-The-Shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual. Regulations at 42 CFR 414.402 define the term "minimal self-adjustment" to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist,an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient. Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for CY 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS. 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, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Prefabricated Orthotic Codes Split into Two Codes—Effective January 1, 2014

Fee from Existing Code	Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes
L0454	L0455 and L0454
L0456	L0457 and L0456
L0466	L0467 and L0466
L0468	L0469 and L0468
L0626	L0641 and L0626
L0627	L0642 and L0627
L0630	L0643 and L0630
L0631	L0648 and L0631
L0633	L0649 and L0633
L0637	L0650 and L0637
L0639	L0651 and L0639
L1810	L1812 and L1810
L1832	L1833 and L1832
L1847	L1848 and L1847
L3807	L3809 and L3807
L3915	L3916 and L3915
L3917	L3918 and L3917
L3923	L3924 and L3923
L3929	L3930 and L3929
L4360	L4361 and L4360
L4386	L4387 and L4386
L4396	L4397 and L4396

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.

Neurostimulator Devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable Neurostimulator, Pulse Generator, Any Type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687 and L8688. The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 Implantable Neurostimulator Pulse Generator which was discontinued effective 12/31/2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies, 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 Diabetic Testing Supplies (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 recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, Change Request (CR) 8204, dated February 22, 2013. You may review the MLN Matters® Articles for these CRs at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and 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 1.0 percent for CY 2014. The single payment amount public use file for the national mail order competitive bidding program is available http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

CY2014 Fee Schedule Update Factor

For CY 2014, the update factor of 1.0 percent is applied to the applicable CY 2013 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 2014 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 2013, 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 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

2014 Update to the Labor Payment Rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014 and those rates are as follows:

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73	NC	14.55	21.68	29.43
AL	14.55	21.68	29.43	ND	18.13	31.16	36.73
AR	14.55	21.68	29.43	NE	14.55	21.66	41.04
AZ	17.99	21.66	36.21	NH	15.62	21.66	29.43
CA	22.32	35.59	41.48	NJ	19.63	21.66	29.43
CO	14.55	21.68	29.43	NM	14.55	21.68	29.43
CT	24.30	22.16	29.43	NV	23.18	21.66	40.12
DC	14.55	21.66	29.43	NY	26.79	21.68	29.43
DE	26.79	21.66	29.43	OH	14.55	21.66	29.43
FL	14.55	21.68	29.43	OK	14.55	21.68	29.43
GA	14.55	21.68	29.43	OR	14.55	21.66	42.32

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
HI	17.99	31.22	36.73	PA	15.62	22.30	29.43
IA	14.55	21.66	35.23	PR	14.55	21.68	29.43
ID	14.55	21.66	29.43	RI	17.34	22.32	29.43
IL	14.55	21.66	29.43	SC	$14.55	21.68	29.43
IN	14.55	21.66	29.43	SD	16.26	21.66	39.35
KS	14.55	21.66	36.73	TN	14.55	21.68	29.43
KY	14.55	27.76	37.64	TX	14.55	21.68	29.43
LA	14.55	21.68	29.43	UT	14.59	21.66	45.83
MA	24.30	21.66	29.43	VA	14.55	21.66	29.43
MD	14.55	21.66	29.43	VI	14.55	21.68	29.43
ME	24.30	21.66	29.43	VT	15.62	21.66	29.43
MI	14.55	21.66	29.43	WA	23.18	31.77	37.74
MN	14.55	21.66	29.43	WI	14.55	21.66	29.43
MO	14.55	21.66	29.43	WV	14.55	21.66	29.43
MS	14.55	21.68	29.43	WY	20.28	28.89	41.04
MT	14.55	21.66	36.73				

2014 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR8531 implements the 2014 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, 2014. 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). The updated 2014 monthly payment amount of $178.24 includes the 1 percent update factor for the 2014 DMEPOS fee schedule.

Please note that 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.

2014 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in MLN Matters® Articles,MM6792 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

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

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a CY 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR8531 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.pdf on the CMS website.

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2014

MLN Matters® Number: MM8527
Related Change Request (CR) #: CR 8527
Related CR Release Date: November 15, 2013
Related CR Transmittal #: R82GI
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment/ Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8527 which details the new Calendar Year (CY) 2014 Medicare premium, coinsurance, and deductible amounts. Make sure that your billing staffs 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 updated rates are as follows:

2014 Part A - Hospital (HI) Rates

Deductible

- $1,216.00

Coinsurance

- $304.00 a day for 61st-90th day
- $608.00 a day for 91st-150th day (lifetime reserve days)
- $152.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)

Base Premium (BP)

- $426.00 a month

BP with 10% surcharge

- $468.60 a month

BP with 45% reduction

- $234.00 a month (for those who have 30-39 quarters of coverage)

BP with 45% reduction and 10% surcharge

- $257.40 a month

2014 Part B - Supplementary Medical Insurance (SMI) Rates

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 8527 issued to your MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R82GI.pdf on the CMS website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8582 Revised
Related Change Request (CR) #: CR 8582
Related CR Release Date: February 24, 2014
Related CR Transmittal #: R2884CP
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: This article was revised on February 27, 2014, to reflect an updated Change Request (CR). The CR corrects the date when the Claim Status Category Codes and Claim Status Codes will be posted, which is March 1, 2014. All other information remains the same.

Provider Types Affected

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

Provider Action Need

This article is based on CR 8582 which informs Medicare contractors about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1). These codes explain the status of submitted claim(s).

Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes on the Internet.

All code changes approved during the January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8582.

Additional Information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads /R2884CP.pdf on the CMS website.

Uniform Use of CARC and RARC Rule

MLN Matters® Number: MM8518
Related Change Request (CR) #: CR 8518
Related CR Release Date: November 15, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1316OTN
Implementation April 7, 2014

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8518, from which this article is taken, instructs Medicare contractors to report only the code combinations that are listed in the current version of the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule. The spreadsheet attached to CR8518 (which is available also at http://www.caqh.org/CORECodeCombinations.php) shows the change log for CORE Code Combination version 3.0.3 updates published on October 1, 2013.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C - Administrative Simplification - to Title XI of the Social Security Act, requiring the Secretary 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.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE published Code Combination version 3.0.3 on October 1, 2013. This update is based on July, 2013 CARC and RARC updates as posted at the WPC website. You may review these updates at: http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

Additional Information

The official instruction, CR 8518 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1316OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

In CR8365, released on August 16, 2013, CMS instructed Medicare contractors to implement this updated rule set by January 6, 2014. You can find the associated MLN Matters® Article, MM8365 "Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8365.pdf on the CMS website.

New Non-Physician Specialty Code for IPP Billers

MLN Matters® Number: MM8282
Related Change Request (CR) #: CR 8282
Related CR Release Date: June 12, 2013
Related CR Transmittal #: R2721CP and R221FM
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

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

Provider Action Needed

Effective October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will use physician specialty code C2 as the primary and/or secondary specialty code for the Indirect Payment Procedure (IPP) billers. IPP billers should self-designate their Medicare specialty on the appropriate Form CMS-855 application when they register in the Medicare program. Specialty codes are used by CMS for programmatic and claims processing purposes.

Background

Certain health benefit plans furnish Medicare complementary coverage for their members. If such an entity qualifies as an IPP biller under 42 CFR section 424.66[i], which may be viewed at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec424-66.pdf, it may seek payment in the Medicare Fee-For-Service program for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier. CR 8282 announces that CMS established a new non-physician specialty code of C2 (Indirect Payment Procedure), effective October 1, 2013. The Provider Enrollment, Chain and Ownership System (PECOS) and MACs will recognize and use this new specialty code.

Additional Information

The official instruction, CR 8282 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2721CP.pdf on the CMS website.
A related transmittal that updates the "Medicare Financial Management Manual" is http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R221FM.pdf on the CMS website.

MREP and PC Print Updates for Operating Rules Phase III 360 Rule Compliance

MLN Matters® Number: MM8479
Related Change Request (CR) #: CR 8479
Related CR Release Date: November 6, 2013
Related CR Transmittal #: R1308OTN
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

What Provider Need to Know

This article is based on Change Request (CR) 8479 which informs Medicare standard system maintainers about changes to documentation requirements for electronic transactions.

Background

Section 1104 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purpose of financial and administrative transactions.

Key Points in CR 8479

- Medicare contractor's systems will publish text describing the Group Code/CARC/RARC/CAGC reject codes included in the remittance advice to trading partners using MREP, PC Print, or PCACE software to view/print all V5010 X12 835 transactions. All published text will contain corresponding code descriptions or definitions specified in the code lists without changing the meaning and intent of the descriptions.
- Medicare contractor's systems will publish text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario on all V5010 X12 835 transactions for trading partners using MREP, PC Print, or PCACE software to view/print v5010 X12 835 transactions.

Additional Information

The official instruction, CR 8479 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1308OTN.pdf on the CMS website.

Claim Adjustment Reason Code 23

MLN Matters® Number: MM8297
Related Change Request (CR) #: CR 8297
Related CR Release Date: November 15, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1318OTN
Implementation Date: April 7, 2014, except July 7, 2014, for suppliers billing DME MACs

Provider Types Affected

This MLN Matters® Article is intended for physicians, Home Health Agencies (HHAs), and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment MACs (DME MACs)) for services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8279, from which this article is taken, modifies Medicare claims processing systems to use Medicare Claim Adjustment Reason Codes (CARC) 23 to report impact of prior payers' adjudication on Medicare payment in the case of a secondary claim.

Background

Effective April 1, 2013, CR8154 – "Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update" modified CARC 23 (The impact of prior payer(s) adjudication including payments and/or adjustments (Use only with Group Code OA)); to include the instruction that it must be used with Group Code OA (Other Adjustment). The Centers for Medicare & Medicaid Services (CMS) has become aware that the modification to this CARC has resulted in some issues for Medicare. (You can find the MLN Matters article associated with CR8154 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8154.pdf on the CMS website.)

CR8297, from which this article is taken, instructs the Medicare's Shared System Maintainers (SSMs) on how to use CARC 23 to report prior payers' adjudication in the case of a secondary claim.

Medicare beneficiaries may have multiple coverages that occur either before or after Medicare. If (per Coordination Of Benefits) Medicare is the secondary payer, the adjudication process has to take into consideration how previous payers have adjudicated the claim, and report accordingly on the Remittance Advice (RA). The implementation guide for the current Electronic Remittance Advice (ERA) – ASC X12 Transaction 835 version 5010 - has explicit instruction in the Front Matter, Section 1.10.2.13 (Secondary Payment Reporting Consideration) to:

> *"Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments); and Claim Adjustment Group Code OA (Other Adjustment). Code OA is used to identify this as an administrative adjustment. It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." In these instances, reporting the actual payment would prevent the transaction from balancing.*

Medicare does not have to report everything a previous payer has done, because that information is reported by that payer to the provider through the previous payer's Remittance Advice (RA). In order to generate and send a balanced Medicare RA and Coordination of Benefits (COB) Claim, Medicare should report only the part of previous payers' adjudication that impacts Medicare calculation of payment and adjustments.

Specifically, CR8279 requires the Medicare SSMs to report:

1. The Medicare allowed amount in the appropriate claim or service level "AMT" segment using qualifier AU (claim level) or B6 (service level) in AMT01 (Actual Amount Qualifier Code).
2. Any patient responsibility, remaining after coordination of benefits with the previous payer(s), with Group Code "PR" (Patient Responsibility) and the appropriate Claim Adjustment Reason Code (for example: 1 - Deductible Amount, 2 - Coinsurance Amount).
3. Any further adjustment, taken by Medicare as a result of previous payer(s) payment and/or adjustment(s), with Group Code OA and Claim Adjustment Reason Code 23.

Additional Information

The official instruction, CR8279 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1318OTN.pdf on the CMS website.

Quarterly Results of Widespread Prepayment Review of Claims for Respiratory Assist Device (HCPCS E0470)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0470. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The E0470 review involved three claims, of which three were denied. *Please note that due to the timeframe allowed from claim development, response time by supplier and completion of the review by the contractor, there was a limited amount of claims completed during this initial quarter.

Primary Documentation Errors that Resulted in Denial of Claims

The date of the physician's signature on the detailed written order is after the initial date of service and no dispensing order was submitted. Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file.

The proof of delivery was dated prior to the date of service on the claim. 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 item must be the date of service on the claim.

The documentation provided did not support criterion A per LCD L171 (face-to-face clinical evaluation) was met. The patient must have a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea. (Criteria A of LCD L171)

The documentation did not support criterion B per LCD L171 (qualifying sleep test) was met. The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

1. 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.
2. 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.
   - Hypertension, ischemic heart disease, or history of stroke. (Criteria B of LCD L171).

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination (LCD) L171 and Policy Article A19827.

Suppliers can also review specific policy resources for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/pap_devices.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Correct Coding Reminder – Monitoring Technology Used with Positive Airway PAP and RAD

Many manufacturers of medical devices are now incorporating technology for monitoring and/or downloading various types of patient data. This information is then made available for review by the healthcare provider, DME supplier or in some cases, the beneficiary. This technology may be incorporated into the device itself or added as a separate module. Such technologies include, but are not limited to:

- Smart cards and readers.
- USB/Thumb drive accessories.
- Wired telephonic transmission modules.
- Wireless modems.

For example, Positive Airway Pressure (PAP) Devices and Respiratory Assist Devices (RADs include technology to monitor compliance. This article serves as a reminder for the correct coding of these features.

Suppliers who elect to bill separately for monitoring technology must use HCPCS code A9279 (MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED). Code A9279 is to be used whether the monitoring technology is incorporated as part of the base item, supplied as an add-on module or is a stand-alone item. Claims for A9279 are denied as statutorily noncovered.

A9279 is all-inclusive. Use of multiple instances of A9279 to bill separately for individual features is incorrect coding.

Claims billed for monitoring technologies using other NOC codes such as E1399 [DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS] will be denied as incorrect coding.

Refer to the applicable Local Coverage Determination and related Policy Article for additional information on the coverage and coding of PAP and RAD items.

Coverage Reminder – Speech Generating Devices

Joint DME MAC Publication

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination for Speech Generating Devices (IOM 100-2 §50.1), specifies that in order for a speech generating device (SGD) to be considered for reimbursement under the Durable Medical Equipment (DME) benefit, it must be a "dedicated" device. Dedicated device means that the SGD must be a device limited solely to the generation of speech, for use only by the individual who has a severe speech impairment. The NCD states:

Devices that would not meet the definition of speech generating devices and therefore, do not fall within the scope of §1861(n) of the Act are characterized by:

- Devices that are not dedicated speech devices, but are devices that are capable of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other than non-medical function.
- Laptop computers, desktop computers, or PDA's which may be programmed to perform the same function as a speech-generating device, are noncovered since they are not primarily medical in nature and do not meet the definition of DME. For this reason, they cannot be considered speech-generating devices for Medicare coverage purposes.
- A device that is useful to someone without severe speech impairment is not considered a speech-generating device for Medicare coverage purposes.

SPEECH GENERATIVE DEVICES

This benefit does not extend coverage to the broader range of augmentative and alternative communications devices (AAC) that have capabilities exceeding the sole function(s) of speech generation such as (not all-inclusive): wireless and cellular communication capabilities, environmental control capability, non-speech generating software (e.g., games, word processing, email).

Products provided as a dedicated device that have the capability to be expanded with additional hardware and/or software or where additional functionality may be made available by "unlocking" hardware or software limitations do not meet the NCD requirement for classification as a dedicated device. Such non-dedicated devices are not eligible for coverage and should be coded A9270 (Noncovered item or service).

SGD Software

For the purposes of Medicare reimbursement, the term SGD also describes Speech Generating Device software/programs installed for use on a personal computer or other device. While the software/program is a covered benefit when all other coverage criteria in the SGD Local Coverage Determination (LCD) and related Policy Article (PA) are met, the device that runs the SGD software (e.g. laptop computer, tablet, smartphone) is not a covered item as it is not primarily medical in nature and does not meet the definition of DME. The installation and technical support of the program on a non-dedicated device is not separately reimbursable. Finally, technical support or repairs (if necessary) is non-covered for the non-dedicated device hosting the SGD software.

Suppliers are reminded that accessories/peripherals (e.g. (not all-inclusive)- keyboards, mice, pointing devices, ocular tracking systems) for use with an SGD are eligible for reimbursement only after a determination has been made that the accessory/peripheral is essential for the effective use of a dedicated SGD as described above and all other coverage criteria in the SGD Local Coverage Determination (LCD) and related Policy Article (PA) are met. In addition, accessories/peripherals for use on a non-dedicated device running SGD software are non-covered.

Suppliers should read the entire LCD and related Policy Article for additional coverage, coding and documentation requirements.

Effective for claims with dates of service on or after September 1, 2014, the only products which may be billed to Medicare for Speech Generating Devices are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification List in DMECS maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code A9270. Products previously listed on DMECS will be end dated on August 31, 2014.

The PDAC coding verification application required for these products is the DME and Supplies application. This application is located on the PDAC website, https://www.dmepdac.com/review/apps_check.html.

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

TENS

Quarterly Results of Widespread Prepayment Review of Claims for TENS Device, Two Lead (HCPCS E0720)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0720. The quarterly edit effectiveness results from August 2013 through November 2013 are as follows:

- The E0720 review involved 24 claims, of which 24 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

Primary Documentation Errors that Resulted in Denial of Claims

The documentation provided does not support usage and frequency. Per LCD L11495, 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 Transcutaneous Electrical Nerve Stimulators (TENS) unit.
  - The typical duration of use each time.
  - The results (effectiveness of therapy).

There was no documentation submitted in response to the Additional Documentation Request (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.

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.

There is no proof of delivery (POD) submitted. Per 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.

The proof of delivery (POD) provided was invalid. Suppliers are required to maintain POD documentation in their files. There are two methods of delivery:

1. Delivery directly to the beneficiary or authorized representative.
2. 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 delivery address is the location where the item was actually delivered e.g., the beneficiary home for items directly delivered to the beneficiary or the retail location if the beneficiary picked the item up from the supplier location.

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

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

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

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

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

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

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for TENS on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/docs/checklists/ transcutaneous_electrical_nerve_stimulators_tens.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Conductive Garment for Delivery of TENS or NMES (HCPCS E0731)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0731. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The E0731 review involved 107 claims, of which 76 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

The documentation provided does not support indication for garment during trial period. A conductive garment is not covered for use with a TENS device during the trial period unless:

- The beneficiary has a documented skin problem prior to the start of the trial period.
- The TENS is reasonable and necessary for the beneficiary.
- If the criteria above are not met for E0731, it will be denied as not reasonable and necessary.

There was no documentation submitted in response to the Additional Documentation Request (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.

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.

There is no proof of delivery (POD) submitted. Per 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.

The proof of delivery (POD) provided was invalid. Suppliers are required to maintain POD documentation in their files. There are two methods of delivery:

1. Delivery directly to the beneficiary or authorized representative.
2. 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 delivery address is the location where the item was actually delivered e.g., the beneficiary home for items directly delivered to the beneficiary or the retail location if the beneficiary picked the item up from the supplier location.

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

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

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

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

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

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

Going Forward

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

Education 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 (TENS) on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/transcutaneous_electrical_nerve_stimulators.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for (TENS) Device, Four or More Leads (HCPCS E0730)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0730. The quarterly edit effectiveness results from October 2013 through January 2014 are as follows:

- The E0730 review involved 71 claims, of which 67 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

Primary Documentation Errors that Resulted in Denial of Claims

There was no documentation submitted in response to the Additional Documentation Request (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.

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 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 Transcutaneous Electrical Nerve Stimulators (TENS) unit.
    - The typical duration of use each time.
    - The results (effectiveness of therapy).

The documentation provided does not support trial period criteria. When used for the treatment of chronic, intractable pain described in section II, the TENS unit must be used by the beneficiary on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

The documentation provided does not support why the 2 leads are insufficient to meet the patient's needs. A TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patient's needs.

Going Forward

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

TENS

Education 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 (TENS) on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/docs/checklists/transcutaneous_electrical_nerve_stimulators_tens.html. 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.

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Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

THERAPEUTIC SHOES

Quarterly Results of Widespread Prepayment Review of Claims for Therapeutic Shoes for Persons with Diabetes (HCPCS A5500)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A5500. The quarterly edit effectiveness results from September 2013 through December 2013 are as follows:

- The A5500 review involved 3,741 claims, of which 3,050 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 82%.

Primary Documentation Errors that Resulted in Denial of Claims

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.
- History of previous foot ulceration of either foot.
- History of pre-ulcerative calluses of either foot.
- Peripheral neuropathy with evidence of callus formation of either foot.
- Foot deformity of either foot.
- 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 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement.
- 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 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

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 6 months prior to delivery of the shoes/inserts.
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as 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. 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.

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.

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.

Going Forward

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

Education 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 specific policy resources for Therapeutic Shoes for Persons with Diabetes on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/therapeutic_shoes_for_persons_with_diabetes.html. 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. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Quarterly Results of Widespread Prepayment Review of Claims for Male Vacuum Erection System (HCPC L7900)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code L7900. The quarterly edit effectiveness results from August 2013 through November 2013 are as follows:

- The L7900 review involved 956 claims, of which 637 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

Primary Documentation Errors that Resulted in Denial of Claims

Documentation submitted did not support medical necessity of the item ordered. 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 of 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)."

An invalid Proof of Delivery (POD) was submitted. 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.

No office notes or medical records were submitted to support coverage criteria. 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.

No proof of delivery was 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), 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.

Going Forward

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

Education 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.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

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