DME Happenings

Jurisdiction D
Issue No. 44
September 2014

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8 am – 4:30 pm CT
Website: www.noridianmedicare.com/dme		
Fax		
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
CERT Medical Documentation		1-701-277-7890
Noridian Email Addresses		
Noridian DME Customer Service		dme@noridian.com
Reopenings and Redeterminations		dmeredeterminations@noridian.com
Noridian DME Endeavor		dmeendeavor@noridian.com

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

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

2014 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Off-the-Phone Training	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
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	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
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. – 4:30 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 7, 2014	8:30 a.m. – 10 a.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. – 4:30 p.m. CT
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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the

prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

CMS Quarterly Provider Updates

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

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.

FYI

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
2	Accreditation	Updated link	07/07/14
2	Supplier Standards	Updated abbreviated standards	07/07/14
2	NSC Contact Information	Updated email information	07/07/14
4	Transmission of CMN	Updated title	07/07/14
6	Example of Assigned Claim	Updated dollar amount	07/07/14
6	CMS-1500 Claim Form	Updated information on form version	07/07/14
8	Billing Software	Removed Express Plus Information	07/07/14
8	Benefits	Updated link	07/07/14
11	MSP Recovery Contractor	Updated link	07/07/14
15	Overpayments and Refunds	Updated overpayment amounts	07/07/14
16	Coding Jurisdiction	Updated link	07/07/14
Appendix	Resources	Added email addresses	07/07/14
Appendix	Resources	Added/Updated Fax Numbers	07/07/14
Appendix	Resources	Updated information for BCRC	07/07/14

APPEALS

Telephone Reopenings: Resources for Success

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

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

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

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

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

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

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

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

Clarification of Billing Instructions Related to Home Health Benefit

MLN Matters® Number: MM8775
Related CR Release Date: June 20, 2014
Related CR Transmittal #: R2977CP
Related Change Request (CR) #: CR 8775
Effective Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10
Implementation Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10

Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and suppliers of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed

This article is based on Change Request (CR) 8775, which updates the "Medicare Claims Processing Manual," to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

Background

CR 8775 makes a variety of small changes to the "Medicare Claims Processing Manual". These changes do not reflect any new policy. These changes fall into one of three categories.

1. **Clarification to Home Health Consolidated Billing (HH CB) Instructions**: In 2003, CR 2705 made changes to Medicare systems to bypass services from Home Health Consolidated Billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the "Medicare Claims Processing Manual". CR8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR8775, and you will find a link to that CR in the "Additional Information" section of this article.
2. **Removal of References to the Home Health Advance Beneficiary Notice (HHABN)**: CR 8404 described the use of the Advance Beneficiary Notice of Noncoverage (ABN) as a replacement for the HH ABN. CR8775 makes conforming changes to Chapter 10 to remove references to the HHABN.
3. **Conforming to National Standards**: CR8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee's Official UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

Note: MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

Additional Information

The official instruction, CR 8775, issued to your MAC regarding this change, is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2977CP.pdf on the CMS website.

Clean Claims – Payment/Interest

The Medicare statute provides for claims payment "floors" and "ceilings." A floor is the minimum amount of time a claim must be held before payment can be released. The payment floor date is determined by counting the number of days since the day the claim was received, i.e., the count begins the day after the day of receipt and ends on the day payment is made.

Suppliers who file clean paper claims will not be paid before the 29th day after the date of receipt of their claims, i.e., a 28-day payment floor. However, clean claims filed electronically can be paid as early as 14 days after receipt, i.e., a 13-day payment floor.

The difference in payment floors is incentive for suppliers to consider use of electronic claims submission to increase the timeliness of their cash flow.

A ceiling is the maximum time allowed for processing a "clean" claim before Medicare owes interest to a supplier. Interest must be paid on claims that are not paid within the ceiling period. The count starts on the day after the receipt date and ends on the date payment is made. Interest payments will begin on the 31st day after the date of receipt for clean electronic and paper claims that are not yet paid.

A "clean" claim is one that does not require investigation or development outside the DME MAC operation on a prepayment basis.

Source: *CMS Manual System, Pub. 100-04, Medicare Claims Processing, Chapter 1, Sections 80.2.1.1 and 80.2.1.2*

Healthcare Provider Taxonomy Codes – October 2014 Update

MLN Matters® Number: MM8866
Related Change Request (CR) #: CR 8866
Related CR Release Date: August 22, 2014
Related CR Transmittal #: R3037CP
Effective Date: October 1, 2014
Implementation Date: January 5, 2015 – If capable, MACs can implement this effective October 1, 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 (HH&H) MACs and Durable Medical Equipment (DME) MACs for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8866 implements the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Codes (HPTC) code set that is effective on October 1, 2014, and instructs MACs 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) X12 837 institutional and professional Technical Report Type 3 (TR3s) require the NUCC HPTC set be used to identify provider specialty information on a health care claim. The standards do not mandate the reporting of provider specialty information via a HPTC on every claim, nor for every provider to be identified by specialty.

The standard implementation guides state this information is:

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

Note: Medicare does not use HPTCs to adjudicate its claims. It 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 code 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. 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 HPTC set is maintained by the NUCC for standardized classification of health care providers. 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) website at www.wpc-edi.com/codes on the internet.

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; and
- Inactive items are red.

Additional Information

The official instruction, CR8866 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3037CP.pdf on the CMS website.

MUE Program – Revised Modification

MLN Matters® Number: MM8853
Related Change Request (CR) #: CR 8853
Related CR Release Date: August 15, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R14210TN
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8853 informs MACs about additional modifications being updated in the Medically Unlikely Edit (MUE) Program. The updates include clarifications, general processing instructions, and detailed explanations of MUE requirements and specifications. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. At that time, CMS introduced a new data field to the MUE edit table termed "MUE adjudication indicator" or "MAI". CMS is currently assigning a MAI to each HCPCS code. CR8853 contains current and updated background information for these modifications, including general processing instructions.

MUEs for HCPCS codes with a MAI of "1"
MUEs for HCPCS codes with a MAI of "1" will continue to be adjudicated as a claim line edit.

MUEs for HCPCS codes with a MAI of "2"
MUEs for HCPCS codes with a MAI of "2" are absolute date of service edit. These are "per day edits based on policy". HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and the MACs.

Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and National Correct Coding Initiatives (NCCI) manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for Current Procedural Terminology (CPT) 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

Although the Qualified Independent Contractors (QICs) and the Administrative Law Judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and are being made aware that CMS considers all edits with an MAI of 2 to be firm limits based on subregulatory guidance, while some MUE edits with an MAI "2" may be based directly on regulation or statute.

MUEs for HCPCS codes with a MAI of "3"
MUEs for HCPCS codes with a MAI of "3" are date of service edits. These are "per day edits based on clinical benchmarks". If claim denials based on these edits are appealed, MACs may pay UOS in excess

of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General Processing Instructions
Since ambulatory surgical center (ASC) providers (specialty code 49) cannot report modifier 50, the MUE value used for editing will be doubled for HCPCS codes with an MAI of "2" or "3" if the bilateral surgery indicator for the HCPCS code is "1".

- CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that you bring to their attention.
- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to your MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of "1" or "3" may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.
- Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of "3", MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of "1." CMS interprets the notice delivery requirements under Section1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.
- CMS reminds providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the "Medicare Claims Processing Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Down loads/clm104c34.pdf on the CMS website. Clerical errors (which includes minor errors and omissions) may be treated as reopenings.
- CMS encourages providers to change and resubmit their own claims where possible and to change their coding practices, but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR.
- CMS also reminds providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.
- On your Remittance Advice, MACs will continue to use Group Code CO (contractual obligation), and remark codes N362 and MA01 for claims that fail the MUE edits, when the UOS on the claim exceed the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.

Additional Information

The official instruction, CR 8853 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.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.

Quick Look CERT Documentation Chart

Noridian provides a reference guide of common Comprehensive Error Rate Testing (CERT) policies under review and the documentation that is usually required for the policy criteria to be met.

The policies include:

- Ankle-Foot Orthoses (AFO)
- Enteral Nutrition
- Glucose Monitor & Supplies
- Immunosuppressive Drugs
- Lower Limb Prostheses
- Manual Wheelchairs
- Nebulizers & Supplies
- Oxygen & Supplies
- Positive Airway Pressure Devices & Supplies
- Power Wheelchairs, Seating and Accessories
- Transcutaneous Electrical Nerve Stimulators (TENS)

This is not an all-inclusive list; it is meant to be used as a quick reference chart.

CODING

Correct Coding – Vibration Therapy Devices

Vibration therapy is the application of a vibratory stimulation to the body. It can be applied as in a variety of ways, ranging from whole-body vibration to stimulation of local areas such as joints, hands, face, etc. (not all-inclusive). It is promoted as a treatment for numerous conditions such as arthritis, joint swelling, headache, neuropathic pain, restless legs, etc. (not all-inclusive).

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the Medicare program. This is true even though the item has some remote medically related use. Vibration devices are considered to be massage modalities. As such they are not eligible to be classified as Durable Medical Equipment. Claims for these items must be coded using:

A9270: Non-Covered Item or Service

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

COMPETITIVE BIDDING

Competitive Bidding Program: Correction to VMS Processing of Wheelchair Accessory Claims for Round 2

MLN Matters® Number: MM8864
Related Change Request (CR) #: CR 8864
Related CR Release Date: August 15, 2014
Related CR Transmittal #: R14200TN
Effective Date: January 1, 2015
Implementation Date: January 5, 2015 – For claims processed on and after January 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) for standard power wheelchair and manual wheelchair accessories furnished to Medicare beneficiaries who reside in competitively bid areas (CBAs) as well as some items for beneficiaries residing outside a CBA.

Provider Action Needed

Change Request (CR) 8864 is a clarification of CR8181 that gave providers guidance regarding the Centers for Medicare & Medicaid Services (CMS) claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in a CBA.

For the purpose of CR8864, "Round 1" refers to the original Round 1 and not the Round 1 Rebid. "Round 2" refers to Round 2 and any subsequent Rounds (such as the Round 2 Recompete).

CR8864 implements corrections within Medicare systems to address the following:

1. Payments for wheelchair accessories furnished for use with Complex Group 2 and Group 3 Power Wheelchairs (identified by HCPCS K0835 – K0843 and K0848 – K0864) by contract suppliers for beneficiaries residing in a CBA;
2. Payments for competitively bid wheelchair accessories furnished for use with wheelchair base units that were not bid in Round 1 or Round 2 by contract and non-contract suppliers for beneficiaries residing in a CBA;

3. Payments for competitively bid wheelchair accessories that were not bid in Round 1 and that were furnished for use with any wheelchair base unit to beneficiaries residing outside a CBA; and
4. Payments for competitively bid wheelchair accessories that were not bid in Round 1 and that were furnished for use with wheelchair base units that were not competitively bid in Round 2 to beneficiaries residing in a CBA.

Additionally, effective for claims processed on or after January 1, 2015, MACs will allow payment for wheelchair accessories that are furnished for use with a non-competitively bid base unit, even if the accessories are received after the end date of the certificate of medical necessity (CMN). These accessories can be supplied by any Medicare-enrolled supplier provided they append modifier "KY".

Make sure your billing staffs are aware of these changes.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new Competitive Bidding Program 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, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Policy Scenarios

Effective for claims processed on or after January 1, 2015, MACs will apply the policy indicated to payments made for wheelchair accessories during Round 2 in each of the following scenarios:

Scenario 1
In this scenario, MACs will pay the fee schedule amount (-9.5 percent) for the wheelchair accessory used with the non-bid wheelchair base rather than paying the single payment amount (SPA).

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

Scenario 2
In this scenario, MACs will pay the fee schedule amount (5%) for the wheelchair accessory.

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

Scenario 3
In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with any wheelchair base unit (whether competitively bid or not);

- Billed without modifier "KE" or "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides outside a CBA.

Scenario 4
In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2) **OR** for use with a non-competitively bid base unit that was not bid in Round 1 or Round 2 (HCPCS codes K0005, K0009, K0898, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1239);
- Billed with modifier "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

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

Additional Information

The official instruction, CR 8864 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1420OTN.pdf on the CMS website.

To review MLN Matters® Article 8181, you may visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8181.pdf on the CMS website.

DMEPOS Competitive Bidding Round 2 Recompete and National Mail-Order Recompete Announced

On July 15, the Centers for Medicare & Medicaid Services (CMS) announced plans to recompete the supplier contracts awarded in Round 2 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 2 contract period for all product categories expires on June 30, 2016.

Round 2 Recompete

The Round 2 Recompete product categories are:

- Enteral Nutrients, Equipment and Supplies
- General Home Equipment and Related Supplies and Accessories (includes hospital beds and related accessories, group 1 and 2 support surfaces, commode chairs, patient lifts, and seat lifts)
- Nebulizers and Related Supplies
- Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories
- Respiratory Equipment and Related Supplies and Accessories (includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories)
- Standard Mobility Equipment and Related Accessories (includes walkers, standard power and manual wheelchairs, scooters, and related accessories)
- Transcutaneous Electrical Nerve Stimulation (TENS) Devices and Supplies

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website.

CMS is conducting the Round 2 Recompete in the same geographic areas that were included in Round 2. However, as a result of the Office of Management and Budget's updates to the original 91 Round 2 metropolitan statistical areas (MSAs), there are now 90 MSAs for the Round 2 recompete. The Round 2 Recompete competitive bidding areas (CBAs) have nearly the same ZIP codes as the Round 2 CBAs. However, certain ZIP codes have changed since Round 2 and CMS has updated the CBAs to reflect the changes. Also, CBAs that were located in multi-state MSAs have been defined so that no CBA is included in more than one state. A list of the ZIP codes included in each CBA is also available on the CBIC website.

National Mail-Order Recompete
CMS will also be conducting the national mail-order recompete for diabetic testing supplies at the same time as the Round 2 Recompete. The national mail-order recompete will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Important Dates
To ensure that suppliers have ample time to prepare for the competition, CMS has announced the following next steps for the program:

July 15, 2014

- CMS begins pre-bidding supplier awareness program

Fall, 2014

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter, 2015

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

Review and Update Enrollment
Suppliers must maintain accurate information on its CMS-855S with the National Supplier Clearinghouse (NSC) and in the Provider Enrollment, Chain and Ownership System (PECOS).

- Contact information (name, Social Security number, and date of birth) for authorized official(s) and correspondence address.
- Products and services furnished by the enrolled location(s).
- Each state in which the enrolled location(s) provides items and services.
- If you have only one authorized official listed on your enrollment file, consider adding one or more eligible authorized officials to help with registration and bidding. It is important to note that if your file is not current at the time of registration, you may experience delays and/or be unable to register and bid.

Get Licensed
Contracts are only awarded to suppliers who meet all state licensure requirements by the close of the bid window. Therefore, you must have all required state licenses for the physical location(s) that provides the items in the product category(s). Each physical location on your bid must be licensed for the product category by the state in which it provides items and services. Suppliers bidding in the national mail-order recompete must possess all applicable licenses in order to be awarded a contract in this competition. Copies of these licenses should be on file with the NSC and in PECOS.

A licensure guide for each state, the District of Columbia, and the territories are located on the National Suppler Clearinghouse website. These guides provide general licensure requirements for each product category included in the Competitive Bidding Program and contact information for each state's licensing board or agency. These are only guides. Licensing requirements change periodically, and it remains the responsibility of the bidding supplier to identify and obtain all required licenses. For more information about licensure requirements, please consult the appropriate license issuing agency listed on the guides or call the NSC at 866-238-9652.

Get Accredited
In order to submit a bid, each supplier location must be accredited by a CMS approved accrediting organization for the items they provide in a product category. Suppliers who are interested in bidding for a product category and who do not have its location(s) currently accredited for that product category, must take action NOW to get accredited for that product category. Accreditation organizations report any accreditation updates to the NSC, so it is important that you get accredited early so your information will be up-to-date. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation are available on the Medicare Provider-Supplier Enrollment website.

New and Improved CMS.gov Website
In conjunction with the Round 2 Recompete and the national mail-order recompete, CMS has updated the DMEPOS Competitive Bidding website. The website has been streamlined, so users will be able to easily navigate the webpages by specific rounds and topics. Please make sure you bookmark www.cms.gov/DMEPOSCompetitiveBid for the latest information on the DMEPOS Competitive Bidding Program.

Guidance for Correct Claims Submission When Secondary Payers Are Involved

Note: This article is based on SE1217; however, Coordination of Benefits (COB) information has been replaced with Benefits Coordination & Recovery Center (BCRC).

Provider Action Needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

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

Background

Collect full beneficiary health insurance information
It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare Secondary Payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the "MSP Manual" in Chapter 3, Section 20.2.1 at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf on the CMS website. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

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

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

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

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.
2. If the beneficiary has both a Group Health Plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If you believe a claim was inappropriately denied:

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

Contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 if a beneficiary's MSP record needs to be updated.

- The BCRC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the BCRC at 1-405-869-3307, or the beneficiary may need to be on the line to validate the change.
- Please do not call the BCRC to adjust claims or about mistaken payments. They will not be able to assist you.

Key Points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.
- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the BCRC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information.

COORDINATION OF BENEFITS

Additional Information

- Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claims processing contractor at their toll-free number found at https://www.noridianmedicare.com/dme/contact/phone_numbers.html.
- If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the BCRC or the Medicare Coordination of Benefits process, visit the Medicare Coordination of Benefits Web page at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html on the CMS website.
- The Medicare Learning Network (MLN) has a Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff (ICN 006903) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf on the CMS website. This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the BCRC.

COVERAGE

Functional Electrical Stimulation – Coverage and HCPCS Coding – Revised

Originally Published March 2003

Updated July 10, 2014 - This revision updates the codes and adds the ACA 6407 requirements

Effective: August 1, 2014

In April 2003 the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) establishing coverage for functional electrical stimulation (FES) to enable spinal cord injured (SCI) patients to walk (see National Coverage Determinations Manual 100-3 Chapter 1, Part 2, Section 160.12).

Functional electrical stimulation is a technique that uses electrical impulses to activate paralyzed or weak muscles in precise sequence. The Functional Electrical Stimulation (FES) device transmits these electrical impulses via surface electrodes in the same manner as neuromuscular electrical stimulation (NMES). For example, through selective and sequential stimulation of various lower extremity muscle groups, FES can enable spinal cord injured (SCI) patients to walk.

Coverage of NMES (other than FES) to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. There has been no change in coverage criteria when NMES is used to treat disuse atrophy.

Coverage of FES

Medicare will consider coverage of FES for SCI patients who have completed a training program consisting of at least 32 physical therapy sessions with the device, over a period of three months.

Coverage for FES to enhance walking will be limited to SCI patients with diagnosis, ICD-9 code 344.1 (paraplegia - paralysis of both lower limbs), or (when implemented) one of the ICD-10 codes, G04.1 – Tropical spastic paraplegia, G82.21 Paraplegia, complete, G82.22 Paraplegia, incomplete, and with all of the following characteristics:

1. Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve); and,
2. Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently; and,
3. Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction; and,

4. Persons that possess high motivation, commitment and cognitive ability to use such devices for walking; and,
5. Persons that can transfer independently and can demonstrate standing independently for at least three minutes; and,
6. Persons that can demonstrate hand and finger function to manipulate controls; and,
7. Persons with at least six-month post recovery spinal cord injury and restorative surgery; and,
8. Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and,
9. Persons who have demonstrated a willingness to use the device long-term.

FES used to enhance walking for SCI patients with any of the following conditions, will not be covered.

1. Presence of cardiac pacemakers;
2. Severe scoliosis or severe osteoporosis;
3. Irreversible contracture;
4. Autonomic dysreflexia; or
5. Skin disease or cancer at area of stimulation

Indications for FES other than to enable SCI patients to walk will be denied as not medically necessary.

The only settings where therapists with the sufficient skills to provide these services are employed are inpatient hospitals, outpatient hospitals, comprehensive outpatient rehabilitation facilities and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program.

HCPCS Coding

Two codes are used to bill for FES:

E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED

Note that HCPCS codes E0764 and E0770 represent the "entire system" for the FES devices. Therefore, individual components such as walkers, crutches or other supplies must not be billed separately.

Manufacturers of products billed with code E0770 must have the code(s) verified by the Pricing, Data Analysis, and Coding (PDAC). Currently, the only products that are coded E0770 are:

- WalkAide (Innovative Neurotronics)
- Odstock ODFS Pace FES System (Odstock Medical/Boston Brace)
- NESS L300 and H200 devices (Bioness)

Code E0764 does not require code verification by the PDAC; however, currently the only product that is coded E0764 is the Parastep I (Sigmedics).

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

Documentation Requirements

For E0770 to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted to the DME MAC. This order must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DME MAC upon request. If the supplier

bills for this item without first receiving the completed order, the item will be denied as not medically necessary. Items billed to the DME MAC before a signed and dated order has been received by the supplier must be submitted with an EY modifier (No physician or other health care provider order for this item or service) added to each affected HCPCS code.

If all the above criteria for coverage are met, HCPCS codes E0764 and E0770 must be billed with a KX modifier (REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET). If all the coverage criteria listed above are not present, a KX modifier must not be added to the code.

The diagnosis code that describes the condition(s) requiring the use of FES must be added to the claim.

Afforadable Care Act (ACA) 6407 Requirements

Effective for prescriptions dated on or after July 1, 2013
ACA 6407 contains provisions that are applicable to certain specified items in this NCD. The specified items are:

E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM

PRESCRIPTION REQUIREMENTS - WRITTEN ORDERS PRIOR TO DELIVERY

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS code E0764. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. See below for information about the statutory requirements associated with a WOPD.

Specific Documentation Requirements

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items; therefore, a WOPD is required. Refer to the section below for information about these statutory requirements.

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

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

Statutory Requirements

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

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

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

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

- When an item is replaced
- When there is a change in the supplier
- When required by state law

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

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

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

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

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

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

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

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

Date and Timing Requirements
There are specific date and timing requirements:

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

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

Claim Denial

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

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

Providing Temporary Replacement (K0462) while repairing Beneficiary-owned DME

HCPCS K0462 may be billed when providing a temporary replacement, i.e. loaner equipment, for beneficiary-owned DME during a repair. It is appropriate for suppliers to bill loaner equipment equivalent to the beneficiary-owned equipment using HCPCS K0462 during the repair period. HCPCS K0462 is also appropriate to use when loaning individual components to be used on the existing base equipment while the original components are being repaired.

Reimbursement for HCPCS K0462 is limited to one month's rental per repair for the reasonable and necessary loaner equipment.

Suppliers are reminded that when billing HCPCS K0462 to the DME MAC, a narrative must be included on the claim including a description or HCPCS of the loaner equipment provided, what is being repaired and a description of the repair(s). Suppliers are required to maintain detailed records describing the nature of the repair as well as justification for the temporary replacement of the item.

It is inappropriate to bill HCPCS K0462 for a complete replacement of an item or to bill the beneficiary a service charge while repairing their equipment.

Medicare Signature Requirements – Educational Resources for Health Care Professionals

MLN Matters® Number: SE1419

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order or provide Medicare-covered services to Medicare beneficiaries.

Provider Action Needed

Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable. If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted.

Medicare services provided/ordered must be authenticated by the author using an acceptable signature.

Use this article as a reference to available educational resources related to signature requirements for Medicare-covered services.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand signature requirements for Medicare-covered services.

1. **Medicare Quarterly Compliance Newsletter**
   - The Medicare Quarterly Provider Compliance Newsletter (January 2014) highlights Comprehensive Error Rate Testing (CERT) circumstances as a result of insufficient documentation.
2. **Articles**
   - MM5971: "**CR 5550 Clarification – Signature Requirements**" clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It states that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness hospice.
   - MM6100: "**Physician Signature Requirements for Diagnostic Tests**" notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.
   - MM6261: "**Signature and Date Stamps for DME Supplies – Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)**" alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. It states signature and date stamps are not acceptable for use on CMNs and DIFs. Medicare contractors will only accept hand written, facsimiles of original written and electronic signatures and dates on medical documentation for medical review purposes on CMNs and DIFs.
   - MM6698: "**Signature Guidelines for Medical Review Purposes**" outlines the new rules for signatures and adds language of E-Prescribing beginning on or after April 16, 2010. The article covers signature logs and attestation statements. A helpful table summarizing examples where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit a signature log or attestation statement.
   - MM7337: "**Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation**" states, if the narrative is part of the certification or recertification form it must be located immediately above the physician's signature. If the narrative is an addendum to the form, (in addition to the physician's signature on the certification or recertification form) the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician's signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.
   - MM8219: "**Use of Rubber Stamp for Signature**" highlights the exception for the use of rubber stamps in accordance with the Rehabilitation Act of 1973 in the case of the author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. Under this circumstance, by affixing the rubber stamp, the provider is certifying that they have reviewed the document.
   - SE1219: "**A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter**" includes a short section on signature requirements for face-to-face documentation.
   - SE1308: "**Physicians Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)**" addresses the authority of nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) to sign orders, certification, and recertification in SNFs and NFs.
   - SE1405: "**Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-tot-Face Encounter**" notes that the homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by a physician, titled "Home Health Face-to- Face Encounter", and dated.

3. **Fact Sheets:**
   - ICN 905063: "**Power Mobility Devices: Complying with Documentation and Coverage Requirements**" discusses the need for a signature on both the prescription and the detailed product description from the supplier by the treating physician.
   - ICN 905364: "**Complying With Medicare Signature Requirements**" provides answers to questions, as well as a list of resources, about Medicare signature requirements.
   - ICN 905064: "**Continuous and Bi-Level Positive Airway Pressure (CPAP/BPAP) Devices: Complying with Documentation and Coverage Requirements**" states the order/prescription must be signed by the treating physician who ordered the device. The description may be written by someone else, but the treating physician must sign the order.

Additional Information

To review detailed Medicare signature requirements read Chapter 3 of The "Medicare Program Integrity Manual" located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf on the CMS website.

For more information about provider compliance, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website.

The MLN Educational Web Guides' "MLN Guided Pathways to Medicare Resources" help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about protecting the Medicare Trust Fund, refer to the "Protecting the Medicare Trust Fund" section in the "MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html 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

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

MLN Matters® Number: MM8836
Related CR Release Date: July 18, 2014
Related CR Transmittal #: R2990CP
Related Change Request (CR) # CR 8836
Effective Date: October 1, 2014
Implementation Date: October 6, 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 and Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8836 instructs MACs to download and implement the October 2014 Average Sales Price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2014, April 2014, January 2014, and October 2013, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 6, 2014, with dates of service October 1, 2014, through December 31, 2014. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, section 50, of the "Medicare Claims Processing Manual" which is available at http://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website. The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013

Note: CMS requires physicians and other providers to bill using the appropriate HCPCS or Current Procedural Terminology (CPT) code and to accurately report the units of service. Physicians and other providers should ensure the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy, as noted at http://www.cms.gov/Medi care/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html on the CMS website.

Additional Information

The official instruction, CR 8836 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2990CP.pdf on the CMS website.

Intravenous Immune Globulin Demonstration – Implementation

MLN Matters® Number: SE1424

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services to Medicare beneficiaries who are participants in the IVIG demonstration.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider Action Needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of 10/01/2014, and will continue for three years, as long as funding remains available.

Background

Depending on the circumstances, traditional Fee-For-Service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound and is otherwise receiving services under a Medicare Home Health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

IVIG Demonstration

The "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the $45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. In addition, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times, should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary Eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration (on the eligibility file provided by NHIC, Corp., the implementation support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (have a diagnosis of PIDD) under the traditional FFS Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.);
5. The place of service must be the beneficiary's home or a setting that is "home like."

Billing Details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration:

- Q2052 – (Long Description) -Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.
- Q2052-(Short Description) -IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

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

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be $300 each time the IVIG is administered. While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same date of service and place of service code on the claim line as the IVIG (J code) for which it is applicable. If multiple administrations of IVIG are submitted on a single claim, each date of service must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a Group Code of CO (Contractual Obligation), a Remittance Advice Remarks Code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a Claim Adjustment Remarks Code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (Non-covered charge(s)), and a Group Code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare Secondary Payer process as well.

How Beneficiaries can apply for the IVIG Demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration .

CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claims processing systems.

CMS will conduct an initial enrollment period from 8/08/2014 – 9/12/2014. Completed applications must be received by NHIC, Corp. no later than 5 pm Eastern Time on 9/12/2014 to be considered. Incomplete applications will be returned to the beneficiary and will not be reviewed. Beneficiaries will be notified by 9/30/2014 whether or not they have been accepted. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the 9/12/2014 deadline on a rolling basis until enrollment and/or funding limits are reached.

The enrollment application and the application completion guide are available at http://www.medicarenhic.com or through the IVIG Demo Hot Line at: 844-625-6284.

Completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

Applications may be mailed to:

NHIC, Corp. IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to: Fax 781-741-3533

EDUCATIONAL

2014 Ask the Contractor Teleconferences

If you have a question on your mind and are not sure who to ask, the Ask the Contractor Teleconferences (ACTs) are your opportunity to speak directly to Noridian DME. Knowledgeable Noridian staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and include the answer in the posted minutes.

Upcoming 2014 ACT: 3 p.m. CT

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

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

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

ENROLLMENT

Fingerprint-based Background Check Begins August 6, 2014

MLN Matters® Number: SE1427

Provider Types Affected

This MLN Matters® Special Edition article is intended for providers and suppliers subject to fingerprint-based background check, submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Providers or suppliers will receive notification of the fingerprint requirements from their MAC. Initially, not all providers and suppliers in the "high" screening category will be a part of the first phase of the fingerprint-based background check requirement. See the Background section below for more details.

If you receive notification of the fingerprint requirements, you will have 30 days from the date of the letter to be fingerprinted. Make sure that your staffs are aware of these requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) awarded the Fingerprint-based Background Check contract to Accurate Biometrics located in Chicago, Illinois on July 8, 2014. Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the "high" screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare.

Generally the relevant individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed. The relevant individuals will have 30 days from the date of the letter to be fingerprinted.

If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The relevant individuals should contact Accurate Biometrics prior to being fingerprinted to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics may be contacted by phone (866-361-9944) or by accessing their website at www.cmsfingerprinting.com if you have any questions.

If an initial enrollment application is received by the MAC and the provider or supplier is required to obtain a fingerprint-based background check, the MAC will not begin processing the application until the fingerprint-based background check has been completed and the results are received. The effective date of enrollment will be determined by the date the fingerprint results are received.

Additional Information

For more information on the Fingerprint-based Background Check requirement, view MLN Matters® article SE1417, "Implementation of Fingerprint-Based Background Checks", available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf on the CMS website.

You may also want to review MM7350 titled, "Implementation of Provider Enrollment Provisions in CMS-6028-FC" available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7350.pdf on the CMS website.

ICD-10

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

MLN Matters® Number: SE1408 Revised

Related Change Request (CR) #: 7492

This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

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

Key Points of SE1408

General Reporting of ICD-10

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

General Claims Submissions Information

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

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, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

13X	Outpatient Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE – RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note
34X	Home Health – (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

71X	Rural Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
76X	Community Mental Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
81X	Hospice- Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
82X	Hospice – Non hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Table B – Special Outpatient Claims Processing Circumstances

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

Table C – Professional Claims

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

Table D –Supplier Claims

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

Additional Information

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

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

ICD-10 Testing – Acknowledgement Testing with Providers

MLN Matters® Number: MM8858
Related Change Request (CR) #: CR 8858
Related CR Release Date: August 22, 2014
Effective Date: 30 Days From Issuance (See test dates)
Related CR Transmittal #: R1423OTN
Implementation Date: November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.

- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional Information

The official instruction, CR8858 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1423OTN.pdf on the CMS website.

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

ICD-10 Testing Approach – Revised

MLN Matters® Number: SE1409 Revised

This article was revised on July 31, 2014, to show the new ICD-10 implementation date of October 1, 2015. In addition, the portions of the article that discuss ICD-10 acknowledgement testing and end-to-end testing are updated as a result of the new implementation date.

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

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

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

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

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

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at http://www.cms.gov/Medicare/Coverage/Coverage GenInfo/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-Con version-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/Out patientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf on the CMS website. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in the near future.

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

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

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

End-to-End Testing
During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods.

End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available shortly. Volunteer submitters will be selected nationwide to participate in the end-to-end testing. The 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.

Claims Submission Alternatives

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

Additional Information

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

Partial Code Freeze Prior to ICD-10 Implementation – Revised

MLN Matters® Number: SE1240 Revised

This article was revised on August 1, 2014, to make changes as a result of the delay of ICD-10 implementation until October 1, 2015.

Provider Types Affected

This MLN Matters® Special Edition Article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know

At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2014 to October 1, 2015 by final rule CMS-0043-F issued on July 31, 2014. This final rule is available at https://www.federalregister.gov/articles/2014/08/04/2014-18347/change-to-the-compliance-date-for-the-international-classification-of-diseases-10th-revision on the Internet.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012, October 1, 2013, and October 1, 2014, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. No further updates will be made to ICD-9-CM on or after October 1, 2015, as it will no longer be used for reporting; and
- On October 1, 2016, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_Morning_Transcript' file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_ICD9_Meeting_Summary_report.pdf' file. Information on the Code Freeze begins on page 5.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page –** This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/Medicare/Coding/ICD10/index.html and check back regularly for access to ICD-10 implementation information of importance to you. **Note: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.**
- **CMS Sponsored National Provider Conference Calls –** During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.
- **See MLN Matters® Special Edition Article, SE1239**, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf for an overview of what is needed to implement ICD-10.
- **Frequently Asked Questions (FAQs) –** To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/Medicare/Coding/ICD10/index.html , select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

ICD-10

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI)** http://www.wedi.org ; and
- **Health Information and Management Systems Society (HIMSS)** http://www.himss.org/icd10 on the Internet.

MOBILITY DEVICES

Correct Coding – Billing of HCPCS Code E0986

Recently the Pricing, Data Analysis and Coding (PDAC) Contractor and the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received questions regarding HCPCS code E0986 Manual wheelchair accessory, push activated power assist, each.

E0986 is a push-rim activated power assist option for a manual wheelchair in which sensors embedded in specially designed wheels determine the force that is exerted by the beneficiary upon the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. E0986 includes the two drive wheels/motors, batteries and battery charger. Only one unit of service should be billed per manual wheelchair.

Medicare Demonstration Allows for Prior Authorization for Certain PMDs – Revised

MLN Matters® Number: SE1231 Revised

This article was revised on August 7, 2014, to add information regarding the addition of 12 states (Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington) to the demonstration.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for Medicare Fee-For-Service (FFS) suppliers who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Power Mobility Devices (PMDs) in the demonstration states (Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What You Need to Know

PMDs includes power wheelchairs and Power-Operated Vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of Durable Medical Equipment (DME) for Medicare coverage purposes.

Power Operated Vehicles (POVs or scooters): Under the Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, or manually operated wheelchair.

In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (Motorized) Wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely

and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare Fee-For-Service Program. CMS is conducting a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines for orders written on or after September 1, 2012. The demonstration was initially implemented in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. **Due to the demonstration's early success, the demonstration will be expanded to 12 additional states: Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington.** These 19 States accounted for 71 percent of the total Medicare PMD expenditures in 2011. The expanded demonstration will be effective for orders written on or after October 1, 2014. This demonstration targets a claim type known to be susceptible to fraud and that has had high rates of improper payments.

The demonstration implements a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration States. The prior authorization request can be completed by the ordering physician/ practitioner or the DME supplier. The physician/practitioner or supplier who submits the request is referred to as the "submitter." The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration States:

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

Group 3 complex rehabilitative power wheelchairs with power options (K0856 through 0864) are excluded.

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the 7 element order, the detailed product description, and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/ practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 2 business days. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non- affirmative prior authorization decision will not be paid by Medicare.

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, the DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/ practitioner, and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision. However, the claim will be subject to prepayment review. CMS currently assesses a payment reduction for orders written on or after December 1, 2012, in the initial demonstration states. CMS will begin to assess a payment reduction for noncompliance with the prior authorization process for any orders written on or after January 1, 2015, in the 12 additional states. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS Competitive Bidding Program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at http://go.cms.gov/PADemo on the CMS website.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key Points

CMS initially conducted this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on the beneficiary's address as reported to the Social Security Administration and recorded in Medicare's Common Working File (CWF). This demonstration will expand to Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington for orders written on or after October 1, 2014. This demonstration involves all four DME MACs.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

Additional Information

The Prior Authorization of Power Mobility Device Section of the CMS web page is at http://go.cms.gov/PADemo on the CMS website.

MLN Matters® Special Edition Article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf on the CMS website.

Please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html for the latest MLN educational products designed to help Medicare FFS Providers understand – and avoid – common billing errors and other improper activities.

You may want to review MLN Matters® article MM8056, which is available at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8056.pdf on the CMS website. The article clarifies that only one G9156 code (for preauthorization incentive payment) may be billed, per beneficiary, per PMD even if the physician or treating practitioner must resubmit the prior authorization request.

Mobility Assistive Equipment Ask the Contractor Teleconference Q&A – June 18, 2014

The information provided in this document is correct at the time of publishing. Prior to taking questions, Noridian provided the following updates:

Online Q&A Sessions

Noridian is excited to offer a new way for suppliers to get answers for their questions. Every Monday from 2–3 p.m. CT, suppliers are able to log on to WebEx and type in their written questions and an Education Representative will be there to assist. These sessions are written questions only and there is no audio portion. To register, go online to https://www.noridianmedicare.com/dme/train/online_qa_session.html.

Website Satisfaction Survey

Noridian would like to remind suppliers that as you navigate through our website, a satisfaction survey may pop up. We encourage everyone to take a few minutes to answer a few questions regarding our website. We review each score and comment and base many of our website enhancements and improvements on these. We want to make our website as easy and efficient for you as possible. Once you take the survey, it will not display again for 30 days.

Questions Asked Prior to the ACT

Q: Does the treating physician that does the face-to-face exam need to be Provider Enrollment, Chain and Ownership System (PECOS) certified if the prescribing physician is PECOS certified?
A: For any of the specified items affected by the Affordable Care Act (ACA)Face-to-Face visit and Written Order Prior to Delivery requirement, both the physician conducting the face-to-face exam and the prescribing physician are required to be enrolled in PECOS.

Q: Will the same requirements be used for power wheelchairs?
A: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added section 1834(a)(1)(E)(iv) which provides that payment may not be made for a motorized or power wheelchair unless the practitioner who has conducted the face-to-face examination him or herself writes the 7-element order.

Q: Can a supplier bill for labor on a warranty recall repair?
A: Medicare may consider the labor charge but only if the warranty specifically excludes labor.

Q: Can a beneficiary use a date stamp when signing paperwork?
A: The method of dating a signature must be the same method of the signature to properly authenticate the signature.

Q: Do the Healthcare Common Procedure Coding System (HCPCS) codes of the items need to be listed on the first month purchase option letter?
A: A description of the base and all options and accessories provided with a complex rehab power wheelchair must be included on the rental/purchase option letter. A description instead of the HCPCS code (or both) should be listed so the beneficiary understands what is being provided.

Q: We have a client who received a power mobility device (PMD) through a Medical Assistance (MA) program prior to Medicare. Now the client is Medicare eligible and needs his PMD fixed but the documentation that was received for MA coverage does not meet Medicare coverage. Are we to bill the repairs to Medicare with an Advance Beneficiary Notice of Noncoverage (ABN) stating he does not meet Medicare coverage criteria so it can potentially be covered by the MA program? Or do we have to make him go in and get a face-to-face and evaluation to qualify for Medicare first before we can do the repair?
A: The supplier may properly execute an ABN if the beneficiary does not qualify for the PMD, or the beneficiary may consider going through the process to qualify, i.e., face-to-face mobility exam, 7-element order, detailed product description, home evaluation. If Medicare does not have the PMD on file because it was paid by another payer, a line item narrative will be required on the labor code to indicate what type of PMD is being repaired and when the beneficiary purchased the item.

Q: We have a client who received a power wheelchair from us and we are not in the Competitive Bid Area (CBA) but after receiving the chair the client moved to a CBA. Do all repairs have to go through a competitive bid contract supplier or is he able to come back to our store for repairs when he comes down to visit family?
A: Repairs can be performed by any Medicare enrolled supplier and does not have to be conducted by a competitive bid contracted supplier. Please refer to the DMEPOS Repair and Replacement Fact Sheet on the CBIC website.

Q: A beneficiary received a Group 3 standard power wheelchair. The beneficiary now qualifies for a Group 3 multiple power option wheelchair. The base code has now changed to a multiple power wheelchair HCPCS code but Medicare is not updating their system to that correct code. If we bill for a repair to a multiple power option wheelchair part would we have to put the lesser HCPCS code of the standard base on the claim note?
A: If a beneficiary's condition changed to the point that a Group 3 multiple power option wheelchair is required, both the base and accessories may be allowed. There must be medical records that support the change in medical need. Noridian recommends going through the Advance Determination of Medicare Coverage (ADMC) process with supporting medical records. If a Group 3 standard base is being retrofit to Group 3 multiple power option wheelchair there must be information submitted that clearly explains the retrofit and medical records to justify the change in equipment.

Questions Asked During the ACT

Q: If a patient owns a Group 4 power wheelchair, which is not covered by Medicare, is there any way that the repairs for that wheelchair would be covered?
A: No, Medicare will not consider payment for the repairs due to the base item not being covered.

Q: A supplier is receiving denials on wheelchair cushions due to it not being five years since the last cushion was purchased. What should they do?
A: Unless the items were lost, stolen or irreparably damaged, Medicare will not cover new cushions within the five year Reasonable Useful Lifetime (RUL).

Q: Is it correct that the Detailed Product Description (DPD) has to be dated after the 7-Element Order (7EO) is signed? It can't be the same date?
A: The DPD has to come after the 7EO. There needs to be a Face-to-Face and then the treating physician would create that 7EO based on the face-to-face information. Once the supplier has received that 7EO, they can then create the DPD. It is possible that the 7EO and DPD are received or created on the same date; but suppliers need to ensure that the DPD comes after the 7EO. If these two elements are performed on the same day, it is recommended that suppliers use a time stamp to indicate the chronicle the sequence of events. It is also highly recommended that suppliers use something other than the fax date as the date stamp due to the fact that during transmission, these can and do get cut off.

PMD Prior Authorization Requests Top Reasons for Non-Affirmation

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

Top Reasons for Non-Affirmed Decisions

- The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home.
- When a power operated vehicle (POV) is requested, the face-to-face examination does not indicate the beneficiary is able to safely transfer to and from the POV, operate the tiller steering system, and maintain postural stability while operating the POV in the home.
- When a power wheelchair is requested, the face-to-face examination documentation does not indicate that the use of a POV has been excluded.
- The documentation does not support the criteria for the PMD requested
- 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.

Educational Resources

It is important 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.

Resources for the Prior Authorization Demonstration are located at the Noridian website. Website resources include instructions on requesting prior authorizations and submitting documentation as well as general information and education regarding the Prior Authorization Request (PAR) demonstration.

Noridian also provides various educational opportunities such as workshops, training and self-paced presentations.

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

Policy Education

The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home.
The beneficiary's medical documentation does not support criterion C per LCD L23598.

- The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform Mobility Related Activities of Daily Living (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.

When a POV is requested, the face-to-face examination does not indicate the beneficiary is able to safely transfer to and from the POV, operate the tiller steering system, and maintain postural stability while operating the POV in the home.

The beneficiary's medical documentation does not support criterion D per LCD L23598. A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

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

When a power wheelchair is requested, the face-to-face examination documentation does not indicate that the use of a POV has been excluded.

The beneficiary's medical records do not support that the beneficiary does not meet coverage criterion D for a POV.

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

The 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:

- 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; or
- 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 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.

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

Power Mobility Devices (K0822 and K0825) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department conducted a service specific review of HCPCS codes K0822 and K0825. The final edit effectiveness results from January 2012 through March 2014 are as follows:

The K0822 review involved 345 claims, of which 275 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 78%.

The K0825 review involved 597 claims, of which 497 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 82%.

Top Denial Reasons

- The documentation does not support the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.
- There was no detailed product description submitted or the detailed product description submitted was invalid.
- The face-to-face examination submitted was incomplete or missing elements.
- The documentation submitted does not support the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- The documentation submitted does not support the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of a power operated vehicle (POV).

Educational Resources

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

Suppliers can also review specific policy resources for Power Mobility Devices on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

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

Policy Education

The documentation does not support the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.
The beneficiary's medical records do not support criterion C.

- 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.

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

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

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

- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

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

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

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

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

The documentation submitted does not support 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 records do not support criterion B.

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

The documentation submitted does not support the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of a power operated vehicle (POV).

The beneficiary's medical records do not support the patient does not meet coverage criteria D, E or F for a power operated vehicle.

- The patient is not able to:
  - Safely transfer to and from a POV, and
  - Operate the tiller steering system, and
  - Maintain postural stability and position while operating the POV in the home.
- The patient's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.

Quarterly Results of Service Specific Prepayment Review of Claims for Power Mobility Devices (HCPCS K0822 and K0825)

Review Results

The Jurisdiction D DME MAC Medical Review Department completed a service specific prepayment review of HCPCS codes K0822 and K0825. This review was initiated based on internal data analysis and prior review results.

Both cases were opened July 23, 2012. A final findings article will be posted upon completion of claim review.

Going Forward

Based on the results of the reviews, Noridian will close both service specific reviews.

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 also provides educational offerings by scheduling supplier workshops, training opportunities, and presentations. Information about probe/error validation reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code J7605 and J7626, nebulizer inhalation drugs. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from April 1 through June 30, 2014, resulted in an overall error rate of 30%.

Top Denial Reasons

- Requested documentation was not received by the contractor within the allotted timeframe.
- There were no medical records submitted to support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9)
- The refill requirements were not met.
- The proof of delivery submitted was invalid.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizer Local Coverage Determination (LCD) L11488 and Policy Article A24942.

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

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

Policy Education

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

There were no medical records submitted to **support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9).**

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

The 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 proof of delivery submitted was invalid.

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 5.8

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

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

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

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

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

- 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.

Negative Pressure Wound Therapy Pumps (HCPCS E2402) Notification of Service Specific Prepayment Probe Review

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

E2402: NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE

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

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

- Treating physician's written order
- Documentation to support the beneficiary meets LCD criteria
- Documentation describing the history, previous treatment regimens (if applicable), and current wound management for which a NPWT pump is being billed
- Documentation describing the wound evaluation and treatment, recorded in the beneficiary's medical record, must indicate regular evaluation and treatment of the beneficiary's wounds
- Documentation from the treating physician describing the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care
- Proof of delivery
- The Advanced Beneficiary Notice (if applicable)
- Any other supporting documentation

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Negative Pressure Wound Therapy Pumps Local Coverage Determination (LCD) L11489 and Policy Article A35425.

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.

Therapeutic Shoes (HCPCS A5500) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code A5500. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The A5500 review involved 2219 claims, of which 1865 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **84%**.

Top Denial Reasons

- Documentation of foot abnormalities by certifying physician not met
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation of diabetes management by certifying physician not met
- Documentation of in-person visit prior to selection of items not met

Going Forward

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

Educational Resources

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

Suppliers can also review specific policy resources for Therapeutic Shoes on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist for Therapeutic Shoes on the Noridian website.

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

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

Policy Education

Documentation of foot abnormalities by certifying physician not met.
There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

- Previous amputation of the other foot, or part of either foot, or
- History of previous foot ulceration of either foot, or
- History of pre-ulcerative calluses of either foot, or
- Peripheral neuropathy with evidence of callus formation of either foot, or
- Foot deformity of either foot, or
- Poor circulation in either foot.

In order to meet criterion 2, the certifying physician must either:

- Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
- Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D. or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria above.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

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

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

Documentation of 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; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as 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.**

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.

Ankle-Foot Orthosis (HCPCS L1970) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L1970. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L1970 review involved 295 claims, of which 257 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **86.37%**.

Top Denial Reasons

- The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis
- Documentation submitted was insufficient to support custom coverage criteria

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation submitted was insufficient to support basic coverage criteria

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in Ankle-Foot/Knee-Ankle-Foot Orthosis Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

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

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

Policy Education

The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis.
For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support medical necessity of custom-fabricated rather than a prefabricated orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

Documentation submitted was insufficient to support custom coverage criteria.
AFOs and KAFOs that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

- The beneficiary could not be fit with a prefabricated AFO; or,
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or,
- There is a need to control the knee, ankle or foot in more than one plane; or,
- The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
- The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions.

If a custom-fabricated orthosis is provided but basic coverage criteria and the additional criteria 1-5 for a custom-fabricated orthosis are not met, the custom-fabricated orthosis will be denied as not reasonable and necessary.

No documentation was received in response to Additional Documentation Request letter.

Suppliers have 45 days from the date of the Additional Documentation Request letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Documentation submitted was insufficient to support basic coverage criteria.

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.

Ankle-Foot Orthosis (HCPCS L4360) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L4360. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L4360 review involved 1,152 claims, of which 953 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **83.46%**.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request letter
- Documentation submitted was insufficient to support basic coverage criteria
- No proof of delivery submitted
- Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Ankle-Foot/Knee-Ankle-Foot Orthosis Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

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

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

Policy Education

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Documentation submitted was insufficient to support basic coverage criteria.
Ankle-foot orthoses (AFO) described by codes L1900, L1902–L1990, L2106–L2116, L4350, L4360, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

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

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.
Items requiring substantial modification by a qualified practitioner (as defined in the related Policy Article Coding Guidelines) are coded as custom fitted (L1910, L1930, L1932, L1951, L1971, L2035, L2112-L2116, L2132-L2136, L4360, L4386, L4396). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Custom fitted orthotics are:

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

Ankle-Foot Orthosis (HCPCS L1960) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L1960. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L1960 review involved 184 claims, of which 163 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **86.79%**.

Top Denial Reasons

- The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis
- Documentation submitted was insufficient to support custom coverage criteria
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation submitted was insufficient to support basic coverage criteria

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Ankle-Foot (AFO)/Knee-Ankle-Foot (KAFO) Orthosis Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review a specific policy Documentation Checklist for Ankle-Foot/Knee-Ankle-Foot Orthosis on the Noridian website.

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

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

Policy Education

The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis.
For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support medical necessity of custom-fabricated rather than a prefabricated orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

Documentation submitted was insufficient to support custom coverage criteria.
AFOs and KAFOs that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

- The beneficiary could not be fit with a prefabricated AFO; or,
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or,
- There is a need to control the knee, ankle or foot in more than one plane; or,
- The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
- The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions.

If a custom-fabricated orthosis is provided but basic coverage criteria and the additional criteria 1-5 for a custom-fabricated orthosis are not met, the custom-fabricated orthosis will be denied as not reasonable and necessary.

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Documentation submitted was insufficient to support basic coverage criteria.
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.

Ankle-Foot Orthoses: Walking Boots – Coverage and Coding Issues – Revised

Originally Published March 2004
Updated July 10, 2014

HCPCS codes L4360, L4361, L4386 and L4387 describe an ankle-foot orthosis commonly referred to as a walking boot. Walking boots that are used to provide immobilization as treatment for an orthopedic condition or following orthopedic surgery are eligible for coverage under the Brace benefit. When walking boots are used primarily to relieve pressure, especially on the sole of the foot, or are used for patients with foot ulcers, they are noncovered - no benefit category. Medicare covers therapeutic shoes, as described in the Therapeutic Shoes for Persons with Diabetes local coverage determination (LCD), for the prevention and treatment of diabetic foot ulcers.

Suppliers must add a GY modifier to HCPCS code L4360, L4361, L4386 or L4387 if the walking boot is only being used for the treatment or prevention of a foot ulcer. The absence of a GY modifier indicates that the walking boot is being used as part of the treatment for an orthopedic condition or following orthopedic surgery. Claims for HCPCS code L4360, L4361, L4386 or L4387 with a GY modifier will be denied as noncovered.

Prefabricated walking boots must be billed with HCPCS codes L4360, L4361, L4386 or L4387. Add-on codes must not be billed in addition to these HCPCS codes. Custom fabricated walking boots must be billed with HCPCS code L2999 and must be accompanied by information identifying the manufacturer and model name (if applicable), the indication(s) for use of the boot, and an explanation of why a prefabricated walking boot is not sufficient. Walking boots must not be billed with other AFO HCPCS codes, including but not limited to HCPCS codes L2106-L2116, or with HCPCS codes for therapeutic shoes.

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

Correct Coding – Palatal Lift Prosthesis

A palatal lift prosthesis is a dental appliance that is used to support the soft palate in individuals lacking the normal muscle function necessary to maintain the soft palate in its normal position.

Claims are occasionally submitted to the DME MACs using Not Otherwise Classified (NOC) HCPCS codes. When a specific code exists for any item, use of a NOC code is incorrect coding. The specific codes to be used on claims for a palatal prosthesis are:

D5955 – Palatal lift prosthesis, definitive

D5958 – Palatal lift prosthesis, interim

D5959 – Palatal lift prosthesis, modification

Current Dental Terminology (CDT) D codes are not within DME MAC jurisdiction. Claims for D codes must be submitted to the local carrier. Claims for D codes submitted to the DME MAC will be denied as wrong jurisdiction.

Claims for palatal lift prostheses submitted to the DME MAC using other HCPCS NOC codes will be denied as incorrect coding.

External Breast Prosthesis (HCPCS L8030) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L8030. The final edit effectiveness results from January 2013 through August 2014 are as follows:

The L8030 review involved 3207 claims, of which 2038 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 61%.

Top Denial Reasons

No documentation was received in response to Additional Documentation Request (ADR) letter

- No office notes or medical records were submitted to support coverage criteria
- An invalid proof of delivery (POD) was submitted
- Order submitted was incomplete and/or missing elements

Educational Resources

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

Suppliers can also review a specific policy Documentation Checklist for External Breast Prosthesis on the Noridian website.

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

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

Policy Education

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

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

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.

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.

An invalid proof of delivery (POD) 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 DMEPOS on behalf of the beneficiary.

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

Suppliers are required to maintain POD documentation in their files. There are 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.

Order submitted was incomplete and/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.

Knee Orthoses (HCPCS L1832, L1833, & L1843) Notification of Service Specific Prepayment Probe Review

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

L1832: Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

L1833: Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf

L1843: Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

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

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

- Treating physician's dispensing (if item is dispensed on a dispensing order) and written order
- Patient's medical records (physician medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) that may support the item(s) provided are reasonable and necessary; and,
- The justification for the code selected for a custom fitted vs. off the shelf orthosis (if applicable) and,
- Proof of delivery
- The Advanced Beneficiary Notice (if applicable)
- Any other supporting documentation

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Knee Orthoses Local Coverage Determination (LCD) L27058 and Policy Article A47178.

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.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5981. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L5981 review involved 29 claims, of which 23 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 75.99%.

Top Denial Reasons

- Documentation does not support the functional level billed on the claim
- Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time
- Documentation does not support the beneficiary is motivated to ambulate
- Documentation does not support medical necessity for the item(s) requested

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses (LLP) Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

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

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

Policy Education

Documentation does not support the functional level billed on the claim.
A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to: 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 did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate.
A lower limb prosthesis is covered when the beneficiary:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate

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

Documentation does not support medical necessity for the item(s) requested.
For any item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

For the items addressed in the LLP local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act § 1862(a) (1) (A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5987. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L5987 review involved 18 claims, of which 17 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **82.24%**.

Top Denial Reasons

- Documentation did not support the functional level billed on the claim
- Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time
- Documentation did not support the beneficiary is motivated to ambulate
- No documentation was received in response to Additional Documentation Request letter
- Documentation does not support medical need for replacement item(s)

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses (LLP) Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website**.**

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

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

Policy Education

Documentation did 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 did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate.
A lower limb prosthesis is covered when the beneficiary:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate

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

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Documentation does not support medical need for replacement item(s).
Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following: 1. A change in the physiological condition of the beneficiary; or 2. Irreparable wear of the device or a part of the device; or 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5980. The quarterly edit effectiveness results from February 2014 through May 2014 are as follows:

The L5980 review involved 39 claims, of which 33 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **84%**.

Top Denial Reasons

- Documentation does not support the functional level billed on the claim
- Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Signature requirements were not met

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

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

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

Policy Education

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

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

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

Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time.
Lower limb prosthesis is covered when the beneficiary:

1. Will reach or maintain a defined functional state within a reasonable period of time; and
2. Is motivated to ambulate

No documentation was received in response to Additional Documentation Request letter.

Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Signature requirements were not met.
PIM 3.3.2.4 – For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process should also be used for illegible signatures.

Orthoses/Prostheses – Coding for Professional Services/Fabrication Supplies – Republished

Originally published September 2004
Updated July 10, 2014

HCPCS codes L4205 (Repair of orthotic device, labor component, per 15 minutes) and L7520 (Repair of prosthetic device, labor component, per 15 minutes) may only be billed for time involved with the actual repair of an orthosis or prosthesis, respectively, or for medically necessary adjustments made more than 90 days after delivery.

HCPCS codes L4205 and L7520 must not be used to bill for time involved with other professional services including, but not limited to:

- Evaluating the patient
- Taking measurements, making a cast, making a model, use of CAD/CAM
- Making modifications to a prefabricated item to fit it to the individual patient

- Follow-up visits
- Making adjustments at the time of or within 90 days after delivery

Reimbursement for these services is included in the allowance for the HCPCS codes which describe the orthosis/prosthesis.

Similarly, HCPCS codes L4210 (Repair of orthotic device, repair or replace minor parts) and L7510 (Repair of prosthetic device, repair or replace minor parts) must not be used for casting supplies or other materials used in the fitting or fabrication of an orthosis/prosthesis.

If a supplier decides to submit a claim for services/items that are included in the allowance for the orthosis/prosthesis, HCPCS code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used. HCPCS code L9900 is denied as not separately payable.

Services or supplies associated with the provision of plaster or fiberglass casts or splints are in the jurisdiction of the local carriers and fiscal intermediaries. Claims for these items may not be submitted to the DME MAC.

Orthoses: Replacement of Components Clarification – Republished

Originally Published December 2003
Updated July 10, 2014

The allowance for a prefabricated orthoses includes all components provided at the time of initial issue including, but not limited to, soft interfaces, straps, closures, etc. Replacements of components of covered orthoses are covered if the original component is no longer functional due to wear and cannot be repaired. Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are not covered.

Some replacement items have unique HCPCS codes. For example, replacement soft interfaces used with ankle contracture orthoses or foot drop splints are billed with HCPCS codes L4392 and L4394, respectively. One unit of service of the replacement interface HCPCS code is covered no more often than once every 6 months. Replacement components that do not have a unique HCPCS code must be billed with a "not otherwise specified" code - L1499, L2999, or L3999, whichever is applicable. The claim must include a description of the component provided, the reason for replacement, and the HCPCS code or narrative description of the base orthosis.

Note: HCPCS codes L4040-L4055 do not describe replacement soft interfaces used with contracture orthoses.

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

Spinal Orthoses: LSO (HCPCS L0631) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L0631. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L0631 review involved 553 claims, of which 489 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 88.68%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request letter
- Documentation was insufficient to support Criteria 1
- Documentation was insufficient to support that substantial modifications were made for the custom fitted item billed
- Invalid proof of delivery

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses: TLSO and LSO Local Coverage Determination (LCD) L11459 and Policy Article A23846.

Suppliers can also review a specific policy Documentation Checklist for Spinal Orthoses on the Noridian website.

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

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

Policy Education

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Documentation was insufficient to support Criteria 1.
Lumbar Sacral Orthoses (LSO) and Thoracic Lumbar Sacral Orthoses (TLSO) are covered under the Braces benefit category (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. Items that do not meet the definition of a brace are noncovered.

In order for a beneficiary's orthosis to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.
A spinal orthosis (L0450 - L0651) is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.
Items requiring substantial modification by a qualified practitioner are coded as custom fitted (L0454, L0456, L0458, L0460, L0462, L0464, L0466, L0468, L0470, L0472, L0488, L0490, L0491, L0492, L0626, L0627, L0630, L0631, L0633, L0635, L0637 and L0639). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.

Custom fitted orthotics are:

- Devices that are prefabricated
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

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

The proof of delivery must include:

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

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

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

Spinal Orthoses: LSO (HCPCS L0637) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L0637. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The L0637 review involved 563 claims, of which 489 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 87.14%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request letter
- Documentation was insufficient to support that substantial modifications were made for the custom fitted item billed

- Documentation was insufficient to support Criteria 1
- No proof of delivery submitted

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses: TLSO and LSO Local Coverage Determination (LCD) L11459 and Policy Article A23846.

Suppliers can also review a specific policy Documentation Checklist for Spinal Orthoses on the Noridian website.

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

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

Policy Education

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.
Items requiring substantial modification by a qualified practitioner are coded as custom fitted (L0454, L0456, L0458, L0460, L0462, L0464, L0466, L0468, L0470, L0472, L0488, L0490, L0491, L0492, L0626, L0627, L0630, L0631, L0633, L0635, L0637 and L0639). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.

Custom fitted orthotics are:
Devices that are prefabricated

- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

Documentation was insufficient to support Criteria 1.
Lumbar Sacral Orthoses (LSO) and Thoracic Lumbar Sacral Orthoses (TLSO) are covered under the Braces benefit category (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. Items that do not meet the definition of a brace are noncovered.

In order for a beneficiary's orthosis to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.

A spinal orthosis (L0450 - L0651) is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

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

Spinal Orthoses: LSO (HCPCS L0648 & L0650) Notification of Service Specific Prepayment Probe Review

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

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

L0650: Lumbar-sacral orthosis, sagittal 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 the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

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

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

- Treating physician's dispensing (if item is dispensed on a dispensing order) and written order
- Patient's medical records (physician medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) that may support the item(s) provided are reasonable and necessary; and,
- Justification to support the custom fitted or off the shelf orthosis code billed (if applicable) and,
- Proof of delivery
- The Advanced Beneficiary Notice (if applicable)
- Any other supporting documentation

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses Local Coverage Determination (LCD) L11459 and Policy Article A23846.

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.

Two New "K" Codes for Prefabricated Single and Double Upright Knee Orthoses Furnished Off-The-Shelf

MLN Matters® Number: MM8839
Related Change Request (CR) #: CR 8839
Related CR Release Date: August 8, 2014
Related CR Transmittal #: R3016CP
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8839 announces that, effective October 1, 2014, two new "K" codes (K0901 and K0902) will be established for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS). The addition of these codes will allow the DME MACs to correctly adjudicate claims. Make sure your billing staffs are aware of these changes.

Background

Definitions

- The orthotics currently paid under Section 1834(h) (Payment for Prosthetic Devices and Orthotics and Prosthetics) of the Social Security Act (the Act), and that are described in its Section 1861(s)(9) (Part E—Miscellaneous Provisions, Definitions of Services, Institutions, etc.) are leg, arm, back, and neck braces. (You can find these sections of the Act at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm, and http://www.ssa.gov/OP_Home/ssact/title18/1861.htm, respectively).
- The "Medicare Benefit Policy Manual," Chapter 15 (Covered Medical and Other Health Services), Section 130 (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) provides the longstanding Medicare definition of "braces" as "rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body." (You can find this manual section at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website).
- Further, Section 1847(a)(2) of the Act defines OTS orthotics as those for which payment would otherwise be made under Section 1834(h), above; which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. You can find this section of the act at http://www.ssa.gov/OP_Home/ssact/title18/1847.htm.
- Lastly, the Center for Medicare & Medicaid Services (CMS) regulations at 42 CFR 414.402, which you can find at http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/html/CFR-2007-title42-vol3-sec414-402.htm, define the term "minimal self-adjustment" as "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 (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training."

New OTS Orthotics Healthcare Common Procedure Coding System (HCPCS) Codes

In February 2012, CMS issued guidance that initially identified specific HCPCS codes that were considered OTS orthoses. The list of HCPCS codes that were finalized as part of this review as OTS orthotics, effective January 1, 2014, are available for download at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

CR8839announces that in order to identify prefabricated single and double upright knee orthoses that are furnished in a variety of standard sizes and do not require the skills of an expert to measure and fit to the individual; the following OTS codes will be added to the HCPCS code set, effective October 1, 2014:

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

Additional Information

The official instruction, CR8839 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3016CP.pdf on the CMS website.

OVERPAYMENTS AND REFUNDS

Refunds to Medicare

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

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

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

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

PECOS

Preventing PECOS Denials for Invalid Ordering Physician Name

This article provides reminders on how to avoid unprocessable claim denials for the Provider Enrollment, Chain & Ordering System (PECOS) ordering physician name errors. Noridian receives on average 350 claims per week with errors in the ordering physician name.

These errors can easily be avoided by doing the following:

- Properly reporting the first and last name of the ordering physician. On paper claims, the ordering physician name should be reported as first name, followed by last name in Item 17 on the CMS-1500 claim form, e.g., John Smith. Do not include credentials or initials in the name.

- For electronic claims, make sure that the first and last names are submitted in the correct field and not reversed.
- Report the first and last name of the ordering physician exactly as listed on the CMS PECOS files, found on the CMS website or accessible through the Interactive Voice Response (IVR) system. Below are instructions on how to use these sources of ordering physician name data.
    - Checking the CMS ordering/referring provider downloadable report containing the National Provider Identifier (NPI), first name, and last name of providers enrolled in PECOS located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html
    - Calling the Noridian IVR, 1-877-320-0390 and selecting Option 6 to enter the NPI and name of the referring provider. The IVR will then respond if the individual is or is not enrolled in PECOS.

The remittance advice will display the following codes when claims are denied due to an error in the ordering physician name:

N264 Missing/incomplete/invalid ordering provider name

N575 Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records

The claim must be corrected and rebilled.

Preventing PECOS Denials for Invalid Ordering Physician NPI

This article provides reminders on how to avoid unprocessable claim denials for the Provider Enrollment, Chain & Ownership System (PECOS) ordering physician National Provider Identifier (NPI) errors. Noridian receives on average of over 1,000 claims per week with an invalid NPI that is not currently active in PECOS.

These errors can easily be avoided by doing the following:

1. Verify whether the provider is a specialty that can order DMEPOS. We have seen DME items ordered by opticians and occupational therapists. These healthcare professionals cannot order DME, per statute.

   In addition, interns or residents who have been assigned an NPI must also be registered and active in PECOS for their NPI to be used on Medicare claims and for the claim to be paid. See more guidance below:

   Orders or referrals by interns or residents: The IFC (interim final rule with comment period) 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.

   Only the following can order DME per Medicare guidelines.
   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, and
   - Clinical Social Workers

2. Verify that the ordering physician NPI is on the list of physicians and other non-physician practitioners enrolled in PECOS. Don't take the ordering provider's word that they are enrolled in PECOS but check one of the following sources, the Interactive Voice Response (IVR) system or CMS list. Just because a provider has an individual NPI does not mean that their enrollment record is in PECOS and is active. Verification of enrollment in PECOS can be done by:
   a. Calling the Noridian IVR, 1-877-320-0390 and selecting Option 6 to enter the NPI and name of the referring provider. The IVR will then respond if the individual is or is not enrolled in PECOS; or
   b. Checking the CMS ordering/referring provider downloadable report containing the NPI, first name, and last name of providers enrolled in PECOS located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html
3. Ensure that the name and the NPI you enter for the ordering provider belong to a physician or non-physician practitioner. A group NPI cannot be used as the ordering NPI on a Medicare claim. In addition, make sure that the qualifier in the electronic claim (2310A NM102 loop) is a 1 (person). Organizations (qualifier 2) cannot order and refer.

The remittance advice will display the following codes when claims are denied due to an error in the ordering physician NPI:

N265 Missing/incomplete/invalid ordering provider primary identifier
N276 Missing/incomplete/invalid other payer referring provider identifier

Claims with these errors must be corrected and rebilled.

Remember also that claims must be filed by one year from the date of service to be considered for payment. We encourage suppliers to rebill claims timely that were denied for PECOS errors after the ordering provider appears on the CMS list or you have been notified by Noridian DME call center representatives that the PECOS issue has been resolved.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0185. The quarterly edit effectiveness results from February 2014 through May 2014 are as follows:

The E0185 review involved 215 claims, of which 146 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 69%.

Top Denial Reasons

- Medical records did not support coverage criteria
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation did not contain a valid date stamp (or similar)
- No office notes or medical records were provided

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces –Group 1 Local Coverage Determination (LCD) L11578 and Policy Article A33678.

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

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

Policy Education

Medical records did not support coverage criteria.
A group 1 mattress overlay or mattress is covered if one of the following three criteria are met: The patient is completely immobile-i.e., patient cannot make changes in body position without assistance, or

- The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
- The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions.

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):

- Impaired nutritional status.
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

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

Documentation did not contain a valid date stamp (or similar).
A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed written order prior to delivery (WOPD) with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

No office notes or medical records were provided.
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.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0277. The quarterly edit effectiveness results from February 2014 through May 2014 are as follows:

The E0277 review involved 151 claims, of which 116 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **74%**.

Top Denial Reasons

- Medical records did not support coverage criteria
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Detailed written order was signed and dated after the date of delivery
- Detailed written order was incomplete and/or missing required elements

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces – Group 2 Local Coverage Determination (LCD) L11579 and Policy Article A35422.

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

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

Policy Education

Medical records did not support coverage criteria.
A group 2 support surface is covered if the beneficiary meets at least one of the following three Criteria:

- The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02-707.05) which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:
  - Use of an appropriate group 1 support surface, and
  - Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
  - Appropriate turning and positioning, and
  - Appropriate wound care, and
  - Appropriate management of moisture/incontinence, and
  - Nutritional assessment and intervention consistent with the overall plan of care
- The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02-707.05),
- The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (ICD-9 707.02 -707.05), and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

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

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

Detailed written order was incomplete and/or missing required 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 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).

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

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

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

The E0181 review involved 333 claims, of which 231 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **71%**.

Top Denial Reasons

- No documentation received in response to Additional Documentation Request letter
- Medical records did not support coverage criteria
- Detailed written order signed and dated after the date of delivery
- Proof of Delivery (POD) invalid

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces Group 1 Local Coverage Determination (LCD) L11587 and Policy Article A33678.

Suppliers can also review a specific policy Documentation Checklist for Pressure Reducing Support Surfaces on the Noridian Website.

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

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

Policy Education

No documentation received
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.

Coverage criteria not met:

1. A group 1 mattress overlay or mattress is covered if one of the following three criteria are met: The patient is completely immobile-i.e., patient cannot make changes in body position without assistance, or
2. The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D.

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface)

1. Impaired nutritional status
2. Fecal or urinary incontinence
3. Altered sensory perception
4. Compromised circulatory status

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

Proof of delivery 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. For items addressed in this policy, 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 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.

REIMBURSEMENT

DMEPOS Fee Schedule – October 2014 Quarterly Update

MLN Matters® Number: MM8865
Related Change Request (CR) #: CR 8865
Related CR Release Date: August 1, 2014
Related CR Transmittal #: R3011CP
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Provider Types Affected

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

Provider Action Needed

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

Background

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

Key Points of CR8865

Splints, Casts, and Certain Intraocular Lenses (IOLs)

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:
A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

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

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

Off-the-Shelf (OTS) Orthotics

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

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

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

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

Specific Coding and Pricing Issues

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

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

Additional Information

The official instruction, CR8865 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3011CP.pdf on the CMS website.

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

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8735
Related Change Request (CR) #: CR 8735
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3043CP
Implementation Date: January 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (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 Change Request (CR) 8735 which informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure your billing staffs 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, more recent HIPAA named versions). 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.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the September/October 2014 committee meeting shall be posted on that site on or about November 1, 2014. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8735.

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 8735.

All MACs must comply with the requirements contained in the versions 004010X093A1 and 005010X212 of ASC X12 276/277 Implementation Guide as well as the 005101X214 of the ASC X12 277 Health Care Claim Acknowledgement Implementation Guide (inclusive of any published Errata documents) and must use valid Claim Status Category Codes and Claim Status Codes when sending 277 responses.

Additional Information

The official instruction, CR 8735 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3043CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of Claim CARC and RARC Rule – Update from CAQH CORE

MLN Matters® Number: MM8838
Related Change Request (CR) #: CR 8838
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3038CP
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8838 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2014. This update is based on July 1, 2014 CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014 under the Patient Protection and Affordable Care Act of 2010. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Social Security 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.

Note: Per Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined Business Scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction, CR8838 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3038CP.pdf on the CMS website.

MREP Enhancement

MLN Matters® Number: MM8856
Related Change Request (CR) #: CR 8856
Related CR Release Date: August 1, 2014
Related CR Transmittal #: R1413OTN
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8856. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare and Medicaid Services (CMS) to help providers to transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR8856 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

Background

CMS offers free software - Medicare Remit Easy Print (MREP) - to view and print HIPAA compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers and suppliers to help them transition to ERA. The MACs will notify MREP users of the MREP enhancements once implementation is complete. A key change in this latest version of the software is an enhancement to correct paging issues when a long claim runs to another page and that subsequent page was missing headers.

Additional Information

The official instruction, CR8856 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1413OTN.pdf on the CMS website.

Continuous Positive Airway Devices (HCPCS E0601KH and E0601KJ) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0601 for the first month of billing (KH modifier) and the 4th-13th month of billing (KJ modifier). The quarterly edit effectiveness results from February, 2014 to May, 2014 are as follows:

The **E0601KH** review involved 2873 claims, of which 1,859 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **63%**.

The **E0601KJ** review involved 1663 claims, of which 1023 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **63%**.

Top Denial Reasons

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

- Documentation submitted did not support criterion one (face-to-face clinical re-evaluation) was met for continued coverage beyond the first three months for (KJ) claims.
- Documentation submitted did not support criterion A (face-to-face clinical evaluation) was met

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (OSA) Local Coverage Determination (LCD) L171 and Policy Article A19827.

Suppliers can also review specific policy resources for PAP Devices for the Treatment of OSA on the Noridian website. This location will provide information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist for PAP Devices for the Treatment of OSA on the Noridian website.

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

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

Policy Education

The Proof of Delivery submitted was invalid.
CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 5.8

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

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

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

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

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

- 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.

No documentation was received in response to Additional Documentation Request letter.
Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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 National Supplier Clearinghouse (NSC).

Documentation submitted 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 submitted did not support criterion 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.

DME CERT Outreach and Education Task Force Oxygen Webinar Available on Our Website!

On July 22, 2014, the DME CERT Outreach and Education Task Force conducted a national webinar outlining CERT error rates found in oxygen claims. That presentation has been uploaded to our website. Click the following link to access the presentation slides: https://www.noridianmedicare.com/dme/train/education_tools.html.

The DME CERT Outreach and Education Task Force consists of representatives from each of the DME MACs and is independent from the CMS CERT Team and CERT Contractors, who are responsible for the calculation of the Medicare Fee-for-Service Improper payment rate. The DME CERT Outreach and Education Task Force seeks to reduce the overall CERT error rate by providing focused education to the supplier community.

Letter To Physician – Home Oxygen Initial Qualification Testing

Dear Physician,

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when 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.

Timing of Physician Visit and Testing
For initial qualification testing scenarios, the beneficiary must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification. In addition, the qualification testing must be performed within 30 days prior to the date of Initial Certification.

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.

Qualifying Test Results
The results of a blood oxygen 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 the test methodology used. The following table summarizes the qualifying results for each group.

	ABG (mm HG)	Oximetry (% Sat)	Notes
Group I	=55	=88	-
Group II	56-59	89	+ Additional disease criteria
Group III	>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; or,
- 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.

Blood oxygen 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.

Please refer to the Local Coverage Determination (LCD) on Oxygen, the related Policy Article and the Supplier Manual for additional information about coverage, billing and documentation requirements. Thank you for your assistance in reducing the CERT error rate.

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

Oxygen (HCPCS E1390) Quarterly Results of Documentation Compliance Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code E1390, oxygen concentrator. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from March 1 through May 31, 2014, resulted in an overall error rate of 27%.

Top Denial Reasons

- Requested documentation was not received by the contractor within the allotted timeframe.
- There was no proof of delivery (POD) submitted or the POD was invalid.
- The documentation provided did not contain the beneficiary's most recent arterial blood gas P02 and/or oxygen saturation test.
- 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).

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Oxygen Local Coverage Determination (LCD) L11457 and Policy Article A33677.

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

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

Policy Education

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

There was no proof of delivery (POD) submitted or the POD was invalid.
CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 5.8 states that:

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

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

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

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

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

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

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

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

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

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

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim. Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Method 3 – Delivery to Nursing Facility on Behalf of a Beneficiary
When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required. When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

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

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.

There was no documentation to support the beneficiary had been seen and evaluated by the treating physician within 30 days prior to the date of the initial Certificate of Medical Necessity (CMN).
LCD L11457 Testing and Visit Requirements states that an evaluation by the treating physician, within 30 days prior to initial certification, is required when the CMN is initiated in the following instances:

- With the first claim for home oxygen, (even if the beneficiary was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO.)
- During the first 36 months of the rental period, when there has been a change in the beneficiary's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. (Please refer to the Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES for additional information.)

Policy Reminder – Positive Airway Pressure Devices – Continued Coverage Beyond First Three Months of Therapy

A review of recent appeals information has identified denials associated with demonstrating compliance with the PAP Local Coverage Determination (LCD) requirements for continued coverage after the initial three months rental. This article is intended as a review of those criteria.

General Requirements

PAP is covered for beneficiaries with obstructive sleep apnea (OSA). The presence of OSA is documented by clinical evaluation and sleep testing. Refer to the LCD for a discussion of the requirements necessary to establish coverage with a diagnosis of obstructive sleep apnea.

Once the diagnosis of OSA is established, the initial three rental months are covered. But by the end of the first three months, there are additional requirements that must be met in order for equipment rental and supply payments to continue. Compliance with these requirements must be documented in the beneficiary's medical record. When the requirements are not met, coverage for more than the first three months is not possible.

There are two requirements for continued coverage. They are:

1. The treating physician must have an in-person visit with the beneficiary no sooner than the 31st day but no later than the 91st day after initiating therapy, conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.
2. There must be objective evidence of the beneficiary's adherence to the use of the PAP device. 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. This information must be reviewed by the treating physician and included in the medical record.

Failure to Meet Payment Requirements

If the above criteria are not met, continued coverage of a PAP device and related accessories beyond the first three months is not possible. Claims for the fourth month and beyond will be denied as not reasonable and necessary.

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

Beneficiaries who fail the initial 12 week trial are eligible to re-qualify for a PAP device but must have both:

1. Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and,
2. Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study.

Change in Equipment

If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial, substitution of an E0470 does not change the length of the trial unless there is less than 30 days remaining in the trial period. If more than 30 days remain in the trial period, the clinical re-evaluation would still occur between the 31st and 91st day following the initiation of an E0601 and objective documentation of adherence on the E0470 would need to occur prior to the 91st day following initiation of the E0601. If less than 30 days remain in the trial period, the clinical re-evaluation and objective documentation of adherence must occur before the 120th day following the initiation of the E0601.

If an E0601 device was used for more than 3 months and the beneficiary was then switched to an E0470, the clinical re-evaluation must occur between the 31st and 91st day following the initiation of the E0470. There would also need to be documentation of adherence to therapy during the 3 month trial with the E0470.

Documentation Requirements

Both PAP devices (E0601 and E0740) are subject to the Affordable Care Act Section 6407 (ACA) requirements. The ACA requires that there be an in-person encounter with a healthcare provider sometime in the 6 months preceding the prescribing of the item. This visit must address some element of the underlying condition(s) that are the basis for the need for the item. The prescription must be a properly completed Medicare "Detailed Written Order". This document is often referred to as a "Written Order Prior to Delivery (WOPD)". This WOPD and the documentation of the face-to-face visit must be in the supplier's file before delivery of the item can occur.

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

Refer to the Positive Airway Pressure Devices LCD and related policy article for additional information about coverage, coding and documentation.

Positive Airway Pressure Device and Respiratory Assist Device – Nasal Interfaces and Liners – Revised

Originally Published June 2005
Updated July 10, 2014

There are two types of nasal interfaces that are used with a Positive Airway Pressure (PAP) device or a Respiratory Assist Device (RAD) - a nasal mask and cannula-type interface.

Both of these types of products are coded A7034 (NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP). HCPC Code A7034 includes the soft interface at initial issue.

HCPCS codes A7032 (CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH) and A7033 (PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR) describe replacement soft interfaces. HCPCS code A7032 is used for a nasal mask interface that goes around the nose, but not into the nostrils. The unit of service for this HCPCS code is "each." HCPCS code A7033 is used for a nasal cannula-type interface. This interface extends a short distance into the nostrils. The unit of service for this code is "pair." For some products, there are two physically separate cushions or "pillows" – one for each nostril. Two cushions/pillows (i.e. "pair") equals one unit of service of HCPCS code A7033. For other products, the interface is a single piece with two protrusions that extend into the nostrils. One of these interfaces equals one unit of service of HCPCS code A7033.

Liners are not interfaces for use with a PAP mask. Liners are products placed between the patient's skin and the PAP mask interface and are made of cloth, silicone or other materials. These are not considered "interfaces" as defined in the PAP Local Coverage Determination (LCD) and related Policy Article, and as described above. Liners must not be billed as replacement interface for a PAP mask using codes such as A7031 (Face mask interface, replacement for full face mask, each) or A7032 (Cushion for use on nasal mask interface, replacement only, each).

A liner used in conjunction with a PAP mask is considered a comfort and convenience item and must be coded A9270 (Noncovered item or service). There is no additional payment for liners used with a PAP mask (see Medicare Benefit Policy Manual 100-2 Chapter 15 Section 110.1).

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

Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0470. The quarterly edit effectiveness results from January 2014 through April 2014 are as follows:

The E0470 review involved 40 claims, of which 28 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 80%.

Top Denial Reasons

- The documentation provided did not support criterion A per Local Coverage Determination (LCD) L171 (face-to-face clinical evaluation) was met.
- The documentation did not support criterion B per LCD L171 (qualifying sleep test) was met.
- The documentation provided did not support the proof of delivery was valid.
- The documentation provided did not support criterion C per LCD L171 (beneficiary/caregiver instructions) was met.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination L171 and Policy Article A19827.

Suppliers can also review specific policy resources for PAP Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website. There you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops

Suppliers can also review a specific policy Documentation Checklist for PAP Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website.

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

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

Policy Education

The documentation provided did not support criterion A per LCD L171 (face-to-face clinical evaluation) was met.
The beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

The 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:

- The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
- The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
    - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
    - Hypertension, ischemic heart disease, or history of stroke. (Criteria B of LCD L171)

The documentation provided did not support the proof of delivery was valid.
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 items on behalf of the beneficiary.

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

The documentation provided did not support criterion C per LCD L171 (beneficiary/caregiver instructions) was met.
The beneficiary and/or their caregiver received instruction from the supplier of the device in the proper use and care of the equipment.

Reminder – Oxygen Equipment and Contents Delivery

Suppliers are reminded that they cannot require a beneficiary to pick up oxygen equipment and contents at the supplier's location or a central dispensing facility. Requiring a beneficiary to pick up their oxygen equipment and contents is a violation of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Standards (42 CFR 424.57(c)) which states:

> *12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.*

Delivery and service is an integral part of oxygen and durable medical equipment (DME) suppliers' costs of doing business. As such, these costs have already been accounted for in the calculation of the fee schedules.

When the DME MACs have knowledge of suppliers requiring beneficiaries to pick up equipment, a referral will be made to the National Supplier Clearinghouse for further investigation of the Supplier Standard violation.

Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0470. The quarterly edit effectiveness results from January 2014 through April 2014 are as follows:

The E0470 review involved 40 claims, of which 28 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 80%.

Top Denial Reasons

- The documentation provided did not support criterion A per Local Coverage Determination (LCD) L171 (face-to-face clinical evaluation) was met.
- The documentation did not support criterion B per LCD L171 (qualifying sleep test) was met.
- The documentation provided did not support the proof of delivery was valid.
- The documentation provided did not support criterion C per LCD L171 (beneficiary/caregiver instructions) was met.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination L171 and Policy Article A19827.

Suppliers can also review specific policy resources for PAP Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website. There you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist for PAP Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website.

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

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

Policy Education

The documentation provided did not support criterion A per LCD L171 (face-to-face clinical evaluation) was met.
The beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

The 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:

- The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
- The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
  - Hypertension, ischemic heart disease, or history of stroke. (Criteria B of LCD L171)

The documentation provided did not support the proof of delivery was valid.
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 items on behalf of the beneficiary.

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

The documentation provided did not support criterion C per LCD L171 (beneficiary/caregiver instructions) was met.
The beneficiary and/or their caregiver received instruction from the supplier of the device in the proper use and care of the equipment.

Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0470. The quarterly edit effectiveness results from January 2014 through April 2014 are as follows:

The E0470 review involved 40 claims, of which 28 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 80%.

Top Denial Reasons

- The documentation provided did not support criterion A per Local Coverage Determination (LCD) L171 (face-to-face clinical evaluation) was met.
- The documentation did not support criterion B per LCD L171 (qualifying sleep test) was met.
- The documentation provided did not support the proof of delivery was valid.
- The documentation provided did not support criterion C per LCD L171 (beneficiary/caregiver instructions) was met.

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination L171 and Policy Article A19827.

Suppliers can also review specific policy resources for PAP Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website. There you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops

Suppliers can also review a specific policy Documentation Checklist for PAP Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website.

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

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

Policy Education

The documentation provided did not support criterion A per LCD L171 (face-to-face clinical evaluation) was met.

The beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

The 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:

- The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
- The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
- Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
- Hypertension, ischemic heart disease, or history of stroke. (Criteria B of LCD L171)

The documentation provided did not support the proof of delivery was valid.
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 items on behalf of the beneficiary.

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

The documentation provided did not support criterion C per LCD L171 (beneficiary/caregiver instructions) was met.
The beneficiary and/or their caregiver received instruction from the supplier of the device in the proper use and care of the equipment.

Supplier Exit from Oxygen Equipment Business – Revised

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 exits the Medicare oxygen business, whether voluntarily or due to revocation of billing privileges, 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 remainder 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 are strongly encouraged to provide a minimum of thirty (30) days notice to the beneficiary of their intention to no longer provide oxygen therapy services. This should be provided in writing and may take one of two forms:

- 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; or,
- 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.

Suppliers exiting through revocation are not subject to the notification requirements suggested above.

Obligations of New Supplier
For suppliers who receive beneficiaries from providers who have exited the Medicare oxygen business, claims for replacement equipment must:

- For the first month claim, append the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,
- Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.
  - When submitting claims electronically, use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 5010A1 electronic claim format.
  - When billing using the Form CMS-1500 paper claim, include the narrative information in item 19 of the claim form.
  - Home health agencies billing using the UB-04 paper claim may report this information in Form Locator 80 (Remarks).

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 include:

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier's services were being terminated; or,
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program; or,
- Attestation statement from the beneficiary indicating that the beneficiary (or their caregiver) has attempted to contact their existing supplier and has been unable to obtain service.

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:

- New order;
- 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.
- 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.

SELF SERVICE TECHNOLOGY

Endeavor Account Deleted if Noridian Contacted by Unauthorized User – Reminder

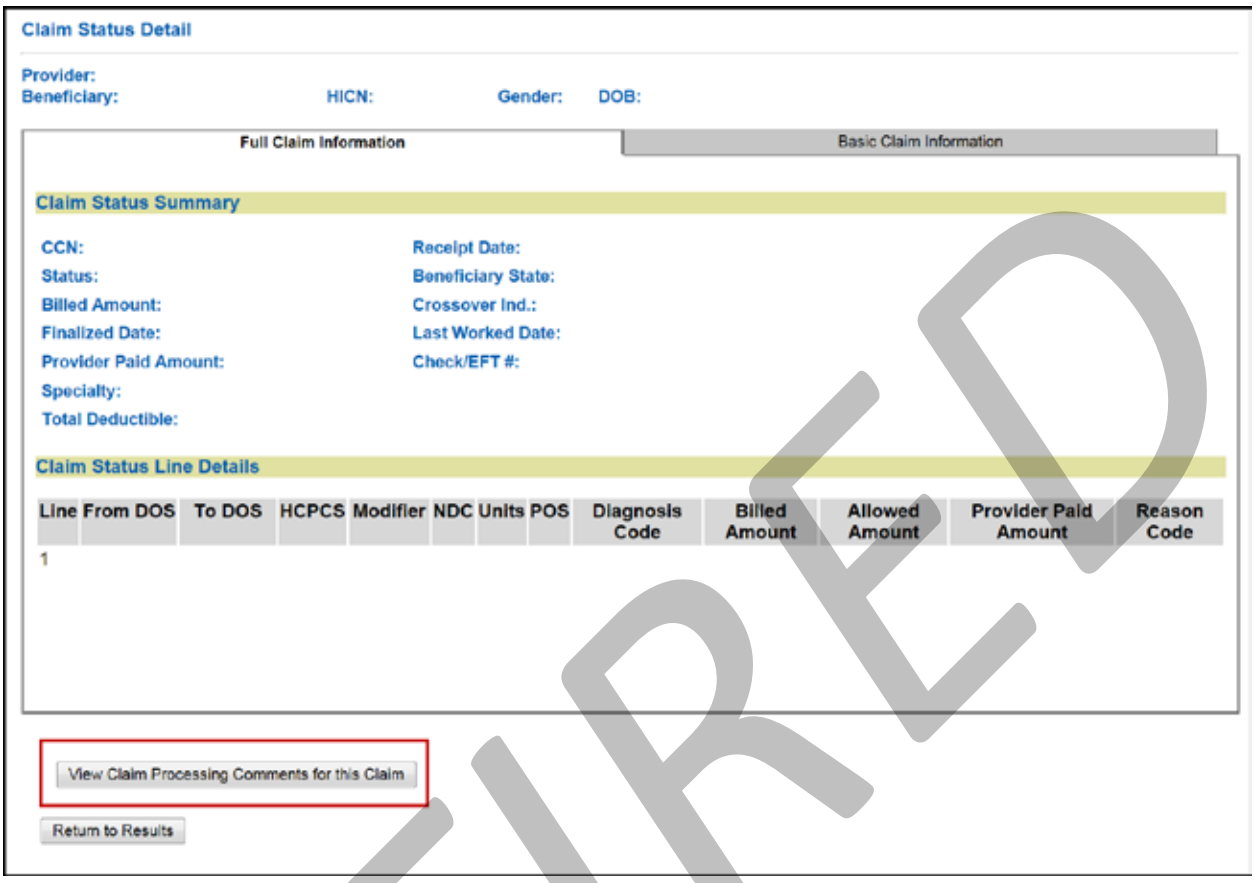
Endeavor accounts will be deleted if someone other than the User listed on the registration contacts Noridian regarding the account. This includes password resets, unlock account requests, change of information, etc.

To read more details, see Endeavor Account Deleted if Noridian Contacted by Unauthorized User.

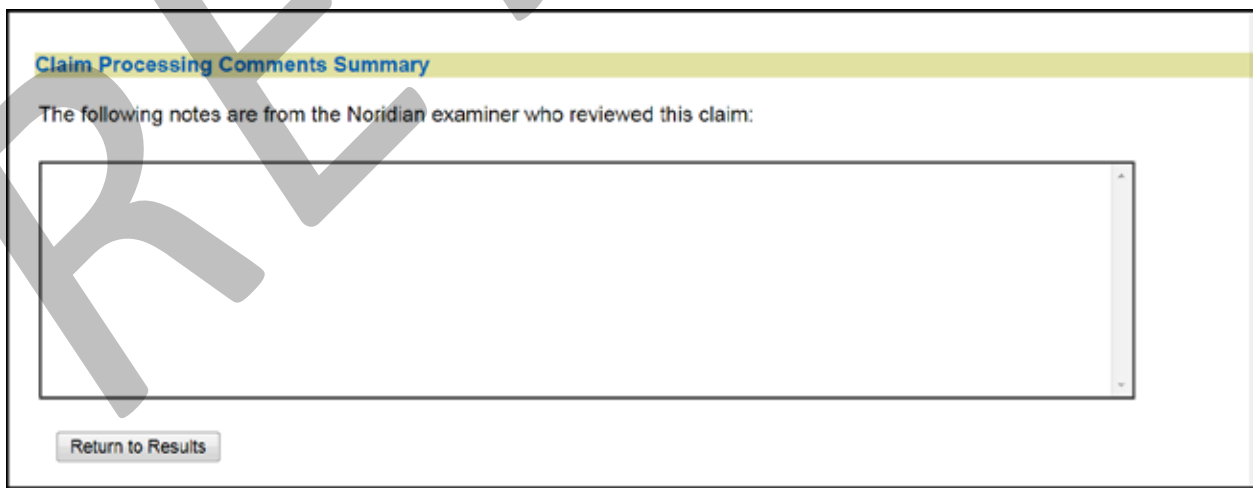
Endeavor Now Offers Claim Comments as Part of Claim Status Results

Effective August 15, 2014, Noridian's Endeavor online portal offers suppliers access to view claim processing comments if a claim had been selected for prepayment review in which Noridian requested documentation prior to making a claim decision. For suppliers who have access to Endeavor's Claim Status functionality, this article describes how Endeavor will provide the detailed claim comments.

First, perform a Claim Status Inquiry by entering the supplier information, beneficiary details and any claim-specific dates if applicable. Next, select the intended claim from the summary of results. If a claim had a history of being reviewed for additional documentation, Endeavor will offer a feature "View Claim Processing Comments for this Claim" beneath the finalized claim.



After selecting this option, the claim processing comments will be retrieved and presented. Protected Health Information is not included within the Noridian examiner's comments. In the event a claim was not suspended during processing, this option will not be presented. There may be a rare occasion where a claim's history does not have comments associated with it; however, Endeavor might offer the "View Claim Processing Comments for this Claim" feature. In this situation, a message will be displayed indicating comments are not available.



Regardless of when a supplier obtains claim details from a remittance advice, the Interactive Voice Response (IVR) system, or from the Endeavor portal, questions regarding the outcome of a finalized claim can be directed to Noridian's contact center.

SELF SERVICE TECHNOLOGY

Website Changes to Help Suppliers Navigate

Effective July 30, Noridian updated four sections of the www.noridianmedicare.com/dme website. This includes the Enrollment, Fee Schedule, Help, and "Welcome New Provider" webpages. The goal of the changes is to let our website visitors know what type of content they can expect to receive while also bringing resources to our suppliers sooner in their navigation steps. The specific website hyperlinks are listed within this article.

Welcome New Supplier: https://www.noridianmedicare.com/dme/news/welcome.html

Fee Schedules: https://www.noridianmedicare.com/dme/fees/

Enrollment: https://www.noridianmedicare.com/dme/enroll/

Help: https://www.noridianmedicare.com/dme/contact/help.html

Suppliers are encouraged to provide website feedback using the resource located within the footer of each webpage as well as complete the website satisfaction survey each time it is presented. Feedback received appreciated and is used to make improvements to our website.

SURETY BOND

Changes to ITR Letter Dates

CMS has made implementations/changes to the Surety Bond process under Change Request 8636. These changes include dates of the Intent to Refer (ITR) letters. The implementation date is in effect on June 17, 2014.

- The date range for sending Intent to Refer (ITR) letters has changed. Suppliers may notice that they are receiving the ITR letter sooner (when the debt has aged 80-90 days).
- After the ITR has been sent, a notification letter is sent to the supplier's Surety Company along with a redacted copy of the ITR. The information that is redacted is the beneficiary's protected health information (HIPAA regulations).
- The surety repayment letter is sent to the supplier's Surety company approximately 30 days after the notification letter has been sent, if the debt has not been paid in full
- The surety company will now have 45 days to repay the debt after the repayment letter is sent, instead of the 30 days that were previously given.

TENS

Electrical Nerve Stimulators Device, Two Lead (HCPCS E0720) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0720. The quarterly edit effectiveness results from February 2014 through May 2014 are as follows:

The E0720 review involved 26 claims, of which 33 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **95%**.

Top Denial Reasons

- The documentation provided does not support usage and frequency
- The order submitted was invalid or incomplete
- The documentation provided does not support other treatments were tried and failed
- The proof of delivery (POD) provided was invalid

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Electrical Nerve Stimulators (TENS) Device, Two Lead Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for Transcutaneous Electrical Nerve Stimulators on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist for TENS Device, Two Lead on the Noridian website.

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

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

Policy Education

The documentation provided does not support usage and frequency.
For chronic pain covered under criterion II, there must be information in the medical record describing:

- The location of the pain
- The severity of the pain
- The duration of time the beneficiary has had the pain
- The presumed etiology of the pain
- Prior treatment and results of that treatment
- Reevaluation of the beneficiary at the end of the trial period, must indicate
  - How often the beneficiary used the TENS unit
  - The typical duration of use each time
  - The results (effectiveness of therapy)

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

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.4)

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

Someone other than the ordering physician may produce the WOPD. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Prescribing physician's National Provider Identifier (NPI) (*Note that only individual NPI numbers must be used. Institutional or group NPI numbers are not acceptable)
- Physician signature and signature date

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

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

The WOPD must be available upon request.

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

The documentation provided does not support other treatments were tried and failed.
Per LCD L11495, Criterion II, Chronic Pain Other than Low Back Pain, TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:

- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
  - headache
  - visceral abdominal pain
  - pelvic pain
  - temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months
- Other appropriate treatment modalities must have been tried and failed

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

The proof of delivery (POD) provided was invalid.
Suppliers are required to maintain POD documentation in their files. There are two methods of delivery:

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

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

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

The 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.

Therapeutic Shoes (HCPCS A5500) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code A5500. The quarterly edit effectiveness results from March 2014 through June 2014 are as follows:

The A5500 review involved 2219 claims, of which 1865 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **84**%.

Top Denial Reasons

- Documentation of foot abnormalities by certifying physician not met
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation of diabetes management by certifying physician not met
- Documentation of in-person visit prior to selection of items not met

Going Forward

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

Educational Resources

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

Suppliers can also review specific policy resources for Therapeutic Shoes on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Suppliers can also review a specific policy Documentation Checklist for Therapeutic Shoes on the Noridian website.

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

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

Policy Education

Documentation of foot abnormalities by certifying physician not met.

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

- Previous amputation of the other foot, or part of either foot, or
- History of previous foot ulceration of either foot, or
- History of pre-ulcerative calluses of either foot, or
- Peripheral neuropathy with evidence of callus formation of either foot, or
- Foot deformity of either foot, or
- Poor circulation in either foot.

In order to meet criterion 2, the certifying physician must either:

- Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
- Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D. or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria above.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

No documentation was received in response to Additional Documentation Request letter.

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

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

Documentation of 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; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as 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.**

THERAPEUTIC SHOES

Documentation of in-person visit prior to selection of items not met.

There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

- An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
- For all shoes, taking measurements of the patient's feet.

For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

VACUUM ERECTION DEVICES

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L7900. The quarterly edit effectiveness results from November 2013 through January 2014 are as follows:

The L7900 review involved 661 claims, of which 447 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **67%**.

Top Denial Reasons

- Documentation did not support the medical necessity of the item ordered
- An invalid proof of delivery (POD) was submitted
- No office notes or medical records were submitted to support coverage criteria
- No documentation was received in response to Additional Documentation Letters (ADR)

Going Forward

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

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the National Coverage Determination for Diagnosis and Treatment of Impotence NCD 230.4. CMS Publication 100-8, *Program Integrity Manual* (PIM) Chapter 5 and the Supplier Manual Chapter 3.

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

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

Policy Education

Documentation did not support medical necessity.
The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by Medicare, the beneficiary's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity 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)."

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

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

WOUND THERAPY

Negative Pressure Wound Therapy Pumps (HCPCS E2402) Notification of Service Specific Prepayment Probe Review

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

E2402: NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE

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

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

- Treating physician's written order
- Documentation to support the beneficiary meets LCD criteria
- Documentation describing the history, previous treatment regimens (if applicable), and current wound management for which a NPWT pump is being billed
- Documentation describing the wound evaluation and treatment, recorded in the beneficiary's medical record, must indicate regular evaluation and treatment of the beneficiary's wounds
- Documentation from the treating physician describing the initial condition of the wound (including measurements) and the efforts to address all aspects of wound care
- Proof of delivery
- The Advanced Beneficiary Notice (if applicable)
- Any other supporting documentation

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Negative Pressure Wound Therapy Pumps Local Coverage Determination (LCD) L11489 and Policy Article A35425.

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

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

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