DME Happenings

Jurisdiction D
Issue No. 41
December 2013

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BILLING

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

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Noridian Healthcare Solutions, LLC

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Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8 am – 4:30 pm CT
Website: www.noridianmedicare.com/dme		
Fax		
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
CERT Medical Documentation		1-701-277-7890
Noridian Email Addresses		
Noridian DME Customer Service	dme@noridian.com	
Reopenings and Redeterminations	dmeredeterminations@noridian.com	
Noridian DME Endeavor	dmeendeavor@noridian.com	
Mailing Addresses		
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian PO Box 6727 Fargo ND 58108-6727	**Benefit Protection** Noridian Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736	
Administrative Simplification Compliance Act Exception Requests Noridian PO Box 6737 Fargo ND 58108-6737	**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32231-4013	
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian PO Box 6728 Fargo ND 58108-6728	**DME Recovery Auditor Overpayments** Noridian PO Box 6759 Fargo ND 58108-6759	

CONTACT US

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

FYI

2013 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Event	Date	Closure Timeframe
Thanksgiving	November 28 and 29	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	December 13	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 20	9:30 a.m. – 12 p.m. CT
Christmas	December 24	12 – 6 p.m. CT
Christmas	December 25	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 – 11:30 a.m. CT to receive training. The holiday and training closures are provided below

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Event	Date	Closure Timeframe
Thanksgiving	November 28 and 29	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	December 6	8 – 10 a.m. CT
Off-the-Phone Training	December 13	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 20	9:30 a.m. – 12 p.m. CT
Christmas	December 24	12 – 4:30 p.m. CT
Christmas	December 25	Entire Day Closed 8 a.m. – 4:30 p.m. CT

Beneficiaries Call 1-800-MEDICARE

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

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

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits
RRB – 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.

Quarterly Provider Updates

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

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

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

How Noridian is Working for You

Noridian makes every effort to listen to supplier feedback, provide great customer service and provide education in a variety of ways, reaching as many suppliers as we can. Below is a recap of our efforts so far in 2013 with these goals:

1. Provided more web-based workshops and in-person seminars, with a focus on orthotics/prosthetics. So far in 2013, 105 web-based workshops and 18 in-person seminars have been offered.
2. Created "DME on Demand" self-paced education brief presentations on specific topics which allows viewers to listen to presentations at their convenience. Thirty-four DME on Demand presentations are available at https://www.noridianmedicare.com/dme/train/education_tools.html. Eleven are on general topics and 23 are for policy specific topics.
3. Collaborated with Part B to educate Ordering Physicians by co-hosting Part B Education events covering the topics of documentation requirements (orders, refill requirements, continued use and continued need), polysomnography and sleep studies and glucose monitors and supplies.
4. Modified claim reviews to decrease the number of documentation requests on the same beneficiary for different months for urological supplies.
5. Conducted analysis and made calls to educate suppliers receiving the PECOS ordering physician edits warning messages on how to correct the error and properly report the ordering physician's name.
6. Medical Review and Appeals staff conduct call-backs to suppliers seeking to better understand documentation requirements and why their specific claims were denied, based upon referrals from the call center.

7. Medical Review staff provide detailed explanations for Power Mobility Device Prior Authorization request non-affirmations, upon supplier request, when the information provided by the call center staff does not offer the detail needed by the supplier.
8. Medical Review staff monitored the number of claims denied for no response to requests for documentation and sent letters to those with the highest non-response rate. These letters explained the impact to the supplier's business when not responding to requests for documentation.
9. Mailed letters to educate suppliers with high error rates on first month oxygen claims. The letters consisted of general educational information, along with customized sections including the individual supplier's detailed error rate, top reasons for denial and specific education based on the identified errors.
10. Updated the letters sent to suppliers as a result of claims suspending for review for the PMD Prior Authorization edits to explain billing requirements and UTN submission to help suppliers avoid billing errors and claim processing delays.
11. Maintained consistency in claim processing through inter-reviewer reliability. Multiple teams make claim payment decisions, including Claims, Appeals and Medical Review. This process promotes ongoing, consistent application of LCDs and other Medicare guidelines and includes a review of claims by all teams for agreement on appropriate processing. This educational, collaborative process results in Noridian being more consistent with claim payments for suppliers, as each team is reviewing the claim the same way and comes to the same decision.
12. Claim staff calls suppliers to provide education on proper billing of claims when they identify issues with billing items out of order, breaks in service vs. breaks in billing and other claim errors.
13. Authored an article, "Physicians Can Help Patients Receiving Medicare Coverage for Supplies and Equipment," which was sent to the Jurisdiction F Medical Associations for publication. The purpose of the article was to provide additional education to physicians regarding DME error rates and requirements.
14. Co-hosted a web-based workshop with the Recovery Auditor to share program information and allow suppliers to ask questions to Noridian as well as Recovery Auditor staff.
15. Added Reconsideration and Administrative Law Judge (ALJ) time limit filing calculators to our website.
16. Held an Appeals Ask the Contractor Call in April and conducted various supplier onsite visits to help suppliers reduce appeals.
17. Added ability to inquire on the status of appeals using the IVR and Endeavor.
18. Created a dedicated ICD-10 web page
19. Enabled workshop attendees to have "Outlook" calendar reminders of workshops they have registered. to attend.
20. Created a CERT email address, jddmecert@noridian.com, to allow suppliers to directly pose their CERT questions to Noridian's DME CERT staff.

The changes described above have been implemented based on supplier feedback. Noridian encourages suppliers to continue to share their feedback regarding what Noridian is doing well and what we should consider changing, within the parameters of fulfilling CMS contractual requirements. Suppliers are encouraged to complete the CMS-sponsored MAC Satisfaction Indicator (MSI) survey and the website satisfaction survey when these feedback tools are offered.

MAC Operations Continue During Shutdown

During the time that the partial government shutdown is in effect, Medicare Administrative Contractors will continue to perform all functions related to Medicare fee-for-service claims processing and payment.

Source: LEARNRESOURCE-L Email Update, National Institutes of Health, U.S. Department of Health and Human Services dated October 1, 2013

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."

Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)

MLN Matters® Number: SE1329

Provider Types Affected

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

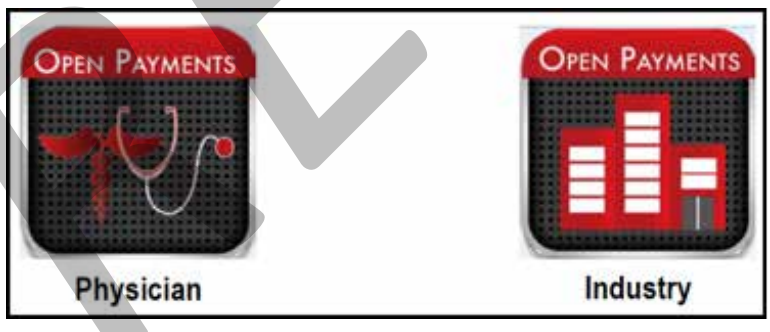
What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announced July 17, 2013, the availability of two new mobile applications (mobile apps) for the OPEN PAYMENTS program (Physician Payments Sunshine Act), which are designed to assist in helping physicians, applicable manufacturers, and applicable Group Purchasing Organizations (GPOs) track much of the data necessary for successful program reporting. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

The two new mobile apps track contact information of physicians and industry, share information between the physician and industry apps using mobile technology, and track payments and other transfers of value in real-time.

One app is targeted specifically to physicians (OPEN PAYMENTS Mobile for Physicians) and the other is for industry, including applicable manufacturers and applicable GPOs (OPEN PAYMENTS Mobile for Industry). A picture of the app icons is shown below.

Ultimately, the goal of these apps is to make tracking payment information easier and more convenient, and to improve the accuracy of payment information by tracking payments as they occur throughout the year.



Additional Information

For more information about the OPEN PAYMENTS program, read the MLN Matters® Special Article SE1303, "Information on the National Physician Payment Transparency Program: OPEN PAYMENTS," available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf on the CMS website.

More information about OPEN PAYMENTS is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html on the CMS website.

Background

Why are these apps needed?

The new OPEN PAYMENTS mobile applications will assist physicians and the industry in tracking financial relationships. The two free mobile apps will help physicians and health care industry users to track their payments and other financial transfers that the industry will report under the OPEN PAYMENTS program (Physician Payments Sunshine Act). Created by a provision of the Affordable Care Act, OPEN PAYMENTS creates greater public transparency about the financial transactions between doctors, teaching hospitals, drug and device manufacturers, and other health care businesses.

CMS has made these apps available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the OPEN PAYMENTS website. CMS's goal is about providing user-friendly tools for doctors, manufacturers, and others in the health care industry to use in working with CMS to implement the law in a smart way. These two apps are innovative options for doctors and the industry to accurately and securely track their financial ties and other transfers of values as required under this important transparency program.

To support the "OPEN PAYMENTS" program, CMS designed the mobile applications (one each for physicians and health care industry users), merging this proven and efficient format with real-time 24-hour tracking technology. The apps offer on-the-go convenience for users to track financial data. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

What are the reporting requirements of OPEN PAYMENTS?

August 2013 marked the beginning of pharmaceutical and device manufacturers and Group Purchasing Organizations (GPOs) collecting and preparing to report payments and other transfers of value made to physicians and teaching hospitals, as well as certain ownership and investment interests, as required by the OPEN PAYMENTS program.

Physicians are not required to report any information to CMS, though they may wish to use this app to help validate reports submitted by manufacturers to CMS about payments they have received. (Reporting requirements do not apply to physician claims payments.)

Financial information entered into the apps will help health care industry entities meet the timely reporting requirements of the OPEN PAYMENTS program. Financial data loaded into the apps does not interact with CMS systems and cannot be used for direct data reporting to CMS or its contractors. In addition, CMS will not validate the accuracy of data stored in the apps, nor will it be responsible for protecting data stored in the apps.

For physician users, the OPEN PAYMENTS Mobile for Physicians mobile app will help them assure that industry information reported about them is accurate by:

- Tracking payments and other transfers of value received from their health care industry affiliations in real-time, as they occur.
- Transferring user profile and high level information associated with the event or situation in which the "transfer of value" occurred between physicians and industry.
- Storing personal contact information.

Industry app users hold the responsibility for accuracy and completeness of their official reports. For industry users, the OPEN PAYMENTS Mobile for Industry mobile app will facilitate their reporting by:

- Tracking their payments and other transfers of value assigned to physicians and teaching hospitals, in real-time.
- Transferring user profile and high level information associated with the event or situation in which the "transfer of value" occurred between physicians and industry.
- Helping to ensure greater accuracy of information about financial relationships with physicians.
- Collecting physician user profile information.

What is a mobile app?
A mobile application (or mobile app) is a software application designed to run on smartphones and other mobile devices.

Is use of the apps completely voluntary?
The use of the apps is voluntary. The apps are available for the user's own information collection and to serve as a personal storage depository only.

How can I obtain the mobile apps?
You can download the mobile apps directly from your app store (e.g., iOS Apple™ or GooglePlay™); search for either OPEN PAYMENTS Mobile for Physicians or OPEN PAYMENTS Mobile for Industry, depending on which app you are downloading and follow your normal downloading instructions.

What if I have questions about the functions and uses of the apps?
For more information on functionality and usage of the apps, visit the Frequently Asked Questions for OPEN PAYMENTS Mobile for Physicians & OPEN PAYMENTS Mobile for Industry document, available at http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Mobile-App-Public-FAQs.pdf on the CMS website.

You can also view a demonstration of the app during the upcoming National Provider Call on August 8, 2013. To register, visit MLN Connects Upcoming Calls at https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html on the CMS website.

For help with the apps you can contact the OPEN PAYMENTS helpdesk at openpayments@cms.hhs.gov. Please also send any comments or suggestions regarding the apps' functionality to our help desk, as we are continuing to explore opportunities to leverage technology solutions that will help enable successful program implementation.

Open Payments (Physician Payments Sunshine Act) Training Modules for Providers

Two Continuing Medical Education Activities are Available

The first module, "Are You Ready for the National Physician Payment Transparency Program?" describes the provisions of Open Payments (Physician Payments Sunshine Act) and its implementation in 2013 – 2014. Through this activity, participants will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions physicians can take to verify their information in advance of website publication. This module can be found at the following address: http://www.medscape.org/viewarticle/780900?src=cmsaca.

Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group are featured in this module.

The goal of the second module, "The Physician Payment Transparency Program and Your Practice" describes the process of collecting, verifying, and publicly reporting transfers of value to physicians and teaching hospitals under Open Payments (Physician Payments Sunshine Act). Through this activity, participants will be able to identify opportunities for physicians to review transfers of value attributed to them and differentiate types of transfers of value that will or will not be reported under Open Payments. This module can be found at the following address: http://www.medscape.org/viewarticle/807771.

Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group, and Anita Griner, Deputy Director of the Data Sharing and Partnership Group, are featured in this module.

Accredited by the Accreditation Council for Continuing Medical

Education, physicians or health care professionals can earn one (1) credit of continuing medical education for the first module and 0.25 credits for the second module. Medscape accounts are free and users do not have to be health care professionals to register. Registration can be found on the Medscape website: www.medscape.com.

Overpayments/Refunds

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Refunds to Medicare form found on the Forms page of the NAS DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form, which NAS 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 Refunds to Medicare form instructions.

A separate interactive form has been created for MSP Inquiries & Refunds. Please use the MSP form for MSP issues.

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, HIC or claim number information is not provided, no appeal rights can be afforded.

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

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

Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
3	Written Order Prior to Delivery	Added information for Affordable Care Act	10/04/13

Sources for "Jurisdiction D Happenings" Articles

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

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

Reconsideration and Administrative Law Judge Time Limit Calculators Now Available

To assist suppliers in submitting timely reconsiderations and Administrative Law Judge (ALJ) requests, Reconsideration and ALJ Time Limit Calculators are now available in the Appeals section of the Noridian website. These calculators allow suppliers to enter the date of the redetermination decision letter or the date of the reconsideration decision letter to determine the submission deadline date. The Submission Deadline is the date by which the request must be received by either the reconsideration contractor or the ALJ. This is based on the 180 day filing limit for reconsiderations and the 60 day filing limit for ALJs established by CMS.

Enter the redetermination decision date or the reconsideration date in mm/dd/yyyy format or use the calendar tool to quickly navigate to the correct month, day and year. Select "Find Submission Deadline." The reconsideration or the ALJ Submission Deadline is returned as a result of the inquiry.

Entry Tips

Do not enter the redetermination decision date or the reconsideration decision date using a 9/4/2012 date format; instead, enter 09/04/2012 to avoid errors.

Calendar Tool Usage

- Use the < and > options to navigate backward or forward one month, respectively.
- Use the << and >> options to navigate backward or forward one year. Select the numeric date for the correct month and year.

Redaction of HICNs in MRNs – Revised

MLN Matters® Number: MM8268
Related Change Request (CR) #: CR 8268
Related CR Release Date: September 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1296OTN
Implementation Date: January 6, 2014

This article was revised on September 27, 2013, to reflect the release of a new Change Request (CR), dated September 25, 2013. The revised CR instructs contractors not auto-populate the HICNs on reconsideration request forms. The transmittal number, CR release date and web address for the CR also changed. All other information remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on CR 8268, which instructs the MACs to redact HICNs on all MRNs. Make sure that your billing staffs are aware of this change.

Background

Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary's HICN. To ensure that contractors protect personally identifiable information, the Centers for Medicare & Medicaid Services (CMS) is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing 5 or more values of the HICN with Xs or asterisks (*) with the last 4 or 5 digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

Additional Information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1296OTN.pdf on the CMS website.

Telephone Reopenings: What Can and Cannot be Requested

Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor to correct a clerical error or omission. A contractor's decision to reopen a claim is not an initial determination and is therefore not appealable.

A telephone reopening must be requested within 12 months after the date of the initial determination. A written reopening can be submitted for claims being requested for a reopening after such 12-month period, but within four years after the date of the initial determination, for good cause. All requests for good cause must be submitted in writing.

How do I request a telephone reopening?	Requesting a telephone reopening is simple, call 1-888-826-5708.
What are the hours of operation for the telephone reopenings?	Monday through Friday 8 a.m. until 4:30 p.m. CT Additional closing information can be found at https://www.noridianmedicare.com/dme/contact/holiday.html.
What do I need to have before I can initiate a telephone reopening?	Before a reopening can be completed, all of the following information must be readily available by the caller and will be verified by the telephone reopening representative. • Supplier Number (Provider Transaction Access Number (PTAN)). • National Provider Identifier (NPI). • The last five digits of the Tax ID Number (TIN). • Supplier name. • Beneficiary Health Insurance Claim Number (HICN). • Beneficiary last name and first initial. • Beneficiary date of birth. • Date of service. • Claim Control Number (CCN) of claim. • Billed amount. Healthcare Common Procedure Coding System (HCPCS) code in question Corrective action to be taken. **NOTE:** If at any time the information does not match the information housed in the claims processing Medicare System, the telephone reopening cannot be completed.
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. This list is not all-inclusive: • Diagnosis changes/additions. • Date of service changes. • HCPCS code changes. Certificate of Medical Necessity (CMN)/DME Information Form (DIF) updates (*with the exception of parenteral and enteral nutrition and oxygen Break In Service (BIS) which must be sent in as a written reopening or redetermination*) Certain modifier changes/additions (not all inclusive list): • KH – DMEPOS item, initial claim, purchase or first month. • KI – DMEPOS item, second or third month rental. • KJ – DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen. • RR – Rental. • Surgical dressing (when number of services are within the policy – if the request is to allow over the policy amount, these must go to written redeterminations). • Wheelchairs – HCPCS K0004 and lower. **NOTE:** If any of the above changes, upon research, are determined to be too complex, the requester will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What is not accepted as a telephone reopening?	The following will not be accepted as a telephone reopening. These items must be submitted along with all supporting documentation as a redetermination: • Any item billed over the allowance listed in the medical policy – documentation is required to support amount billed. • Parenteral and enteral DIF issues. • Oxygen BIS. • Wheelchairs/power mobility devices – HCPCS K0005 and higher. • Recoupment/reduction of payment – complete Refunds to Medicare form. • Medicare Secondary Payer (MSP) – send inquiry to MSP department. • Timely denials – claims submitted within appropriate time frame. • Late files – reopening and/or redetermination requests submitted within the appropriate time frame. • Requests that require documentation. • Advance Beneficiary Notice of Noncoverage (ABN) issues. • A1–A9 modifiers. • GA modifier. • GY modifier. • GZ modifier. • KX modifier. • HCPCS codes J1559, J1561, J1562. • Liability issues. • Repairs to equipment. • Miscellaneous codes. • Labor codes. **NOTE:** Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable and do not have reopening or redetermination rights. The claim is missing information that is needed for processing the claim or the claim information is invalid. These claims must be resubmitted with a new corrected claim.
What do I do when I have a large amount of the same correction?	In the event that a supplier has more than 50 of the same correction, that is able to completed as a reopening, Noridian encourages the supplier to notify the telephone representative. The telephone representative will gather the required information and provide the supplier with direction on what is needed and how to submit the request.
Where can I find more information on telephone reopenings?	Suppliers can utilize Noridian website at https://www.noridianmedicare.com/dme. Supplier Manual, Chapter 13: https://www.noridianmedicare.com/dme/news/manual/chapter13.html. Appeals page: https://www.noridianmedicare.com/dme/appeals/.
Additional Assistance Available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com, excluding any Protected Health Information (PHI) information.

Advance Beneficiary Notice of Noncoverage, Form CMS-R-131

MLN Matters® Number: MM8404
Related Change Request (CR) #: CR 8404
Related CR Release Date: September 6, 2013
Effective Date: December 9, 2013
Related CR Transmittal #: R2782CP
Implementation Date: December 9, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers (including Home Health Agencies) and suppliers that submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (MACs), Regional Home Health Intermediaries (RHHIs), Home Health & Hospice, Medicare Administrative Contractors (HHH MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services to Original Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8404 which provides: 1) instructions for Home Health Agency (HHA) use of the Advance Beneficiary Notice of Noncoverage (ABN) to replace the outgoing Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1; 2) ABN issuance guidelines for therapy services and therapy specific examples; and 3) minor editorial changes to clarify existing manual instructions regarding ABN issuance.

Home health agencies and therapy providers should make sure that their health care and billing staff are aware of these ABN policy changes. All other providers should note that there have been no substantive changes to the ABN form or general instructions for issuance and can reference MM7821 (available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf for general ABN information.

Background

Section 1879 of the Social Security Act (the Act) protects Fee-For-Service (FFS) beneficiaries from payment liability (in certain situations) unless the beneficiary is given advance notice of his/her potential liability. The ABN informs beneficiaries about such possible non-covered charges and fulfills this notification requirement when Limitation of Liability (LOL) applies.

The Centers for Medicare & Medicaid Services (CMS) is expanding use of the ABN to include issuance by home health agency (HHA) providers for Part A and Part B items and services. The ABN will replace the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1 that is currently used by HHAs. The mandatory date for all HHAs to begin use of the ABN and discontinue use of the HHABN will be posted at http://cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html on the CMS website. The guidelines for ABN use published in Chapter 30, Section 50 of the "Medicare Claims Processing Manual" and the ABN form instructions apply to HHAs unless otherwise noted.

Key Points from the Updated Chapter 30 Section 50

HHA Use of ABN – General Use

HHAs are required to issue an ABN to Original Medicare beneficiaries in specific situations where "Limitation on Liability" (LOL) protection is afforded under Section 1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1 below). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary.

ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL projections. HHAs should contact their RHHI if they have questions on the ABN or related instructions, since RHHIs process home health claims for Original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes.

Table 1 – Statutory Provisions Related to ABN Issuance for LOL purposes

Application of LOL for the Home Health Benefit Citation from the Act	Brief Description of Situation	Recommended Explanation for "Reason Medicare May Not Pay" section of ABN
Section 1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.
Section 1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for custodial care, except for some hospice services.
Section 1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit.
Section 1879(g)(1)(B)	Beneficiary does not need skilled nursing care on an intermittent basis	Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit.

If one of the above situations applies and the beneficiary chooses to receive the home care items/services that may not be covered by Medicare, HHAs must issue the ABN to the beneficiary to notify him/her of potential financial responsibility. In addition, when Medicare considers an item or service experimental (e.g., a "Research Use Only" or "Investigational Use Only" laboratory test), payment for the experimental item or service is denied under Section 1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

HHA Triggering Events

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Table 2, below, outlines triggering events specific to HHAs.

Table 2 – Triggering Events for ABN issuance by HHAs*

Event	Description
Initiation	When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.
Reduction	When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.
Termination	When an HHA expects that Medicare coverage will end for all items and services in total.

*ABN issuance is only required when the HHA is going to provide the beneficiary with the item or service that is being initiated, reduced, or terminated as described in this Table. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.

HHA Initiations

The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:

- The care is not medically reasonable and necessary.
- The beneficiary is not confined to his/her home (is not considered homebound.
- The beneficiary does not need skilled nursing care on an intermittent basis.
- The beneficiary is receiving custodial care only.

Note: If the HHA believes that Medicare will not (or may not) pay for care for a reason other than ones listed directly above, issuance of the ABN is not required.

Initiation Example: A beneficiary requires skilled nursing wound care 3 times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA.

The HHA must issue the ABN to this beneficiary before providing the home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether to receive the non-covered care, and to accept the financial obligation.

An ABN, signed at initiation of home health care for items and/or services not covered by Medicare, is effective for up to a year; as long as the items/services being given remain unchanged from those listed on the notice.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events, and is subject to ABN issuance requirements if applicable. When an HHA performs a beneficiary's initial assessment prior to admission but does not admit him/her; an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, it must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions in which a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met (For example, a home health agency cannot issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met).

HHA Reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care that an HHA provides and/or that is part of the Plan of Care (POC). If a reduction occurs for an item or service that will no longer be covered by Medicare, but the beneficiary wants to continue to receive the item or service and will assume the financial charges, the HHA must issue the ABN prior to providing the noncovered items or services (Technically, this is an initiation of noncovered services following a reduction of services).

Reduction With Subsequent Initiation Example: A beneficiary requires Physical Therapy (PT) for gait retraining 5 times per week for 2 weeks, then reduce to 3 times weekly for 2 weeks. After 2 weeks of PT, the beneficiary wants to continue therapy 5 times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

HHA Terminations

A termination is the cessation of all HHA-provided Medicare covered services. If a beneficiary wants to continue receiving home health care that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services; the HHA must issue the beneficiary an ABN in order to charge the beneficiary or a secondary insurer. If the beneficiary will not be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the CMS website under the link for "FFS ED Notices" at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html on the CMS website.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the beneficiary wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued since this would be an initiation of non-covered care.

Effect of Other Insurers/Payers

If a beneficiary is eligible for both Original Medicare and Medicaid (dually eligible) or is covered by Original Medicare and another insurance program or payer (such as waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants), ABN requirements still apply.

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid, but are not covered by Medicare for one of the reasons listed in Table 1; an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.

Some States have specific rules regarding HHA completion of liability notices in situations where dual eligible beneficiaries need to accept liability for Medicare noncovered care that Medicaid will cover. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort" (meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid assumes any remaining charges).

On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise.

Note: If a State has issued a directive to select the third checkbox on the HHABN, HHAs must mark the first check box when issuing the ABN.

Where there is no State specific directive, HHAs are permitted to instruct beneficiaries to select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. HHAs may add a statement in the "Additional Information" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care to your other insurance," or "Your Medical Assistance plan will pay for this care."

HHAs may also use the "Additional Information" on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.

HHA Exceptions to ABN Notification Requirements

ABN issuance is NOT required in the following HHA situations:

- Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge.
- Care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance).
- Telehealth monitoring used as an adjunct to regular covered HH care.
- Noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH Prospective Payment System (PPS) episode payment).

Other HHA ABN Guidance

1. **ABN for Voluntary Notice by HHAs**

   HHAs may use the voluntary ABN, as a courtesy, to alert beneficiaries of impending financial obligation for items and services that are never covered by Medicare as described in the "Medicare Claims Processing Manual," Chapter 30 (Financial Liability Protections), Section 50.3.2 (Voluntary ABN Uses).

2. **Effect of Initial Payment Determinations on Liability**

   An ABN informs a beneficiary of his/her HHA's expectation with regard to Medicare coverage. If the care described on the ABN is actually provided, Medicare makes a payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider's expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider's expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA's expectation, or deny the claim and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

3. **Use of abbreviations**

   When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as "PT" that can have multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

4. **Cost Estimate**

   HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive the care listed on the ABN.

   Cost Estimate Examples:

   - $440 for 4 weekly nursing visits in 1/13.
   - $260 for 3 physical therapy visits 1/3-1/7/13.
   - $50 for spare right arm splint.

When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

Outpatient Therapy Services Use of the ABN

Section 603(c) of the American Taxpayer Relief Act (ATRA) amended Section 1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA amendment, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable.

Now, with this ATRA amendment to the Act, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

Therapists are required to issue an ABN to beneficiaries before providing them therapy that is not medically reasonable and necessary, regardless of the therapy cap. Statutory changes (mentioned above) mandate ABN issuance when therapy services are not medically reasonable and necessary and exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that will not be covered by Medicare because the services are not medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether to obtain the services and accept financial responsibility for them.

Therapy Cap is Not Met – ABN Mandatory Example: A beneficiary has been receiving Physical Therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the Plan of Care (POC). The total amount applied to his therapy cap this year is $780. He requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that will not be covered by Medicare because they are no longer medically necessary.

Therapy Cap Has Been Met – ABN Mandatory: A beneficiary has recently been receiving Physical Therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. She requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Additional Information

The official instruction, CR8404, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf on the CMS website. The revised portions of the "Medicare Claims Processing Manual" are a part of CR8404.

2014 HCPCS Annual Update and Release of Final HCPCS Coding Decision Letters

Although CMS is still assessing the impact of the partial government shutdown on completion of the CY 2014 Healthcare Common Procedure Coding System (HCPCS), CMS intends to publish the 2014 HCPCS Annual Update file on the HCPCS website on or before November 27, 2013. New HCPCS codes will be effective January 1, 2014, unless otherwise specified in the file. Final HCPCS coding decision letters will be mailed to individual applicants to coincide with the publication of the HCPCS Annual Update. Timing of release of the HCPCS file and decision letters is based on the timing of publication of final regulations, as posted on:

- All FFS Provider Center page.
- Physician Center page.
- Hospital Center page.
- Ambulatory Surgical Centers (ASC) Center page.
- Home Health Agency (HHA) Center page.

SNF CB – 2014 Annual Update of HCPCS Codes

MLN Matters® Number: MM8474
Related Change Request (CR) #: CR 8474
Related CR Release Date: October 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2802CP
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHI), and/or Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Provider Action Needed

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 8474 could impact your payments.

This article is based on CR 8474 which provides the 2014 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2013:

- Physicians and other providers who bill carriers or A/B MACs are advised that new code files (entitled 2014 Carrier/A/B MAC Update) will be posted at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html on the Centers for Medicare & Medicaid Services (CMS) website.
- Providers who bill FIs or A/B MACs are advised that new Excel and PDF files (entitled 2014 FI/A/B MAC Update) will be posted to http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html on the CMS website.

It is important and necessary for you to read the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the "Medicare Claims Processing Manual," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 (SNF CB Annual Update Process for Fiscal Intermediaries (FIs)/A/B MACs)) and 110.4.1 (Annual Update Process). You can find this manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf on the CMS website.

CPT codes 11042 (Debride skin/tissue), 11043 (Debride tissue/muscle), and 11044 (Debride tissue/muscle/bone) will be eliminated from the FI/A/B/MAC Minor Surgery INCLUSION list effective 12/31/2012.

Also, note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

The official instruction, CR 8474 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2802CP.pdf on the CMS website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8446
Related Change Request (CR) #: CR 8446
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2792CP
Implementation Date: January 6, 2014

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8446, from which this article is taken, and requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

All code changes approved during the September 2013 committee meeting will be posted on or about November 1, 2013 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/ and are reflected in the X12 277 transactions issued on and after the date of implementation of this CR8446 (January 1, 2014).

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the X12 276/277 Health Care Claim Status Request and Response format.

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on and after the date of implementation of CR8446 (January 1, 2014), your Medicare contractor will:

1. Complete the entry of all applicable code text changes and new codes.
2. Terminate the use of deactivated codes.
3. Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.

Additional Information

The official instruction, CR 8446 issued to your MAC regarding this change may be viewed at http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2792CP.pdf on the CMS website.

CMS-1500 Claim Form Updates: Medicare to Accept Revised Form Starting January 2014

The CMS-1500 Claim Form has been recently revised with changes including those to more adequately support the use of the ICD-10 diagnosis code set. The revised CMS-1500 form (version 02/12) will replace version 08/05. The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes, which is important as the October 1, 2014, transition approaches. ICD-9 codes must be used for services provided before October 1, 2014, while ICD-10 codes should be used for services provided on or after October 1, 2014. The revised form also allows for additional diagnosis codes, expanding from 4 possible codes to 12.

Only providers who qualify for exemptions from electronic submission may submit the CMS-1500 Claim Form to Medicare. For those providers who use service vendors, CMS encourages them to check with their service vendors to determine when they will switch to the new form.

Medicare will begin accepting the revised form on January 6, 2014. Starting April 1, 2014, Medicare will accept only the revised version of the form.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the October 1, 2014, deadline. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

Healthcare Provider Taxonomy Codes - October 2013 Update

MLN Matters® Number: MM8417
Related Change Request (CR) #: CR 8417
Related CR Release Date: August 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2762
Implementation Date: January 6, 2014

Provider Types Affected

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

What You Need To Know

Change Request (CR) 8417, from which this article is taken, instructs Medicare contractors to obtain the most recent Healthcare Provider Taxonomy Codes (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 when electronically transmitting certain health care transactions. These standards contain implementation guides that dictate when and how data must be sent, and specify the code sets that must be used.

Both the current ASC X12 837 institutional and professional claims require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate that a HPTC be on every claim, nor for every provider to be identified by specialty there.

They state that this information is:

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

In addition, please note that Medicare does not use HPTCs to adjudicate its claims, and would not expect to see these codes on a Medicare claim. However, it does currently validate any HPTC that a provider happens to supply against the NUCC HPTC code set.

As the HPTC code set maintainer, the NUCC updates the code set twice a year (effective April 1 and October 1), and CR8417 implements the NUCC HPTC code set that is effective on October 1, 2013.

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

MLN Matters® Number: MM8401 Revised
Related Change Request (CR) #: CR 8401
Related CR Release Date: October 30, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2805CP
Implementation Date: January 6, 2014

Note: This article was revised on November 6, 2013, due to a revised Change Request (CR). The transmittal number, CR Release Date and link to the CR were also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the "Medicare National Coverage Determination (NCD) Manual," Section 310.1.

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

Make sure that your billing staffs are aware of this requirement.

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "Requirements for Including an 8-Digit Clinical Trial Number on Claims" is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf on the CMS website. The MLN Matters® Article for CR5790 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf on the CMS website.

CR8417 instructs Medicare contractors and maintainers to obtain the October 2013 HPTC set, and to update the current HPTC Tables with this updated list. It further instructs the contractors and maintainers that: 1) Have the capability to implement the updated October 2013 HPTC set, to update the HPTC table so that claims received on and after October 1, 2013, can be validated against this updated set; or 2) Lack this capability, to implement the October 2013 HPTC update as soon as they can after October 1, 2013, but not beyond January 6, 2014.

The HPTC set is available for view or for download at http://www.wpc-edi.com/reference/ on the Washington Publishing Company (WPC) website. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code: 1) New items are green; 2) Modified items are orange; and 3) Inactive items are red.

Additional Information

The official instruction, CR8417, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2762CP.pdf on the CMS website.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT.'

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html on the CMS website.

For institutional paper or direct data entry (DDE) claims, the 8-digit clinical trial number is to be placed in the value amount for paper only value code D4/DDE claim UB-04 (For Locators 39-41) when a clinical trial claim includes:

- Condition code 30.
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions).
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30.
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions).
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions).
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below:

- Claim Adjustment Reason Code (CARC) 16: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)"

- RARC MA50: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- Group Code-Contractual Obligation (CO).

Note: This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Additional Information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf on the CMS website.

Place of Service Codes for DMEPOS Claims Reminder

DMEPOS claims, including those for refractive lenses, should never be billed with Place of Service (POS) 11 – Office. The POS should indicate where the beneficiary will primarily use the item provided. Suppliers should be aware any claims billed with POS 11 will be rejected as unprocessable with reason code 16 and remark code MA114. A corrected claim with an appropriate POS for the DMEPOS provided will need to be submitted.

Please see Chapter 5 of our Supplier Manual for a list of POS codes that will be considered for DMEPOS claims.

Revision to VIPS Medicare System Diagnosis Code Editing on CMS-1500

MLN Matters® Number: MM8279
Related Change Request (CR) #: CR 8279
Related CR Release Date: August 5, 2013
Related CR Transmittal #: R2756CP
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8279 which informs Medicare DME MACs about the changes to claims processing edits which require that claims must contain correct diagnosis codes and such codes may not be truncated. In addition, all service diagnosis codes reported on the claim line must be pointed to a valid diagnosis code in the header. Claims submitted on CMS Form-1500, with dates of service on and after January 1, 2014, that contain an invalid header-level diagnosis code will be returned as unprocessable. Make sure that your billing staffs are aware of these changes.

Background

CR8279 provides instructions for handling claims submitted on a CMS Form-1500 that have an invalid, header-level, diagnosis code. In the "Medicare Claims Processing Manual," Chapter 1, Section 80.3.2.1.2, CMS requires that claims submitted with an incorrect or truncated diagnosis code in item 21 of the CMS Form-1500 be returned to the provider as "unprocessable."

BILLING

Currently, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims have been processed and replicated where an invalid diagnosis code was present in the claim header and there was no diagnosis pointer on any service line pointing to the invalid diagnosis code. The processing resulted in the passing on of invalid diagnosis codes and splitting of the claim. CR7700 corrected this issue for claims that are crossed to a Coordination of Benefits Agreement (COBA) trading partner for coordination of benefits purposes, but the issue remained for all other DMEPOS claims.

CR8279 instructs DMEPOS contractors to return as "unprocessable," claims that contain an incorrect or truncated diagnosis code in item 21 of the CMS Form-1500. When returning such claims, your DME MAC will use the following messages:

- Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication).
- Remittance Advice Remarks Code (RARC) 76 (Missing/incomplete/invalid principal diagnosis).
- RARC MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information).
- Group Code CO (Contractual Obligation).

Additional Information

The official instruction, CR8279 issued to your DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2756CP.pdf on the CMS website.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from NAS as the services for which there is no documentation are interpreted as services not rendered.

CMS MLN Connects Provider e-News

AUGUST 8, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-08-Enews.pdf.

MLN Connects™ National Provider Calls

- ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 – Register Now.
- Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program – Register Now.
- ICD-10 Basics – Register Now.
- Did You Miss These MLN Connects Calls?

Other Calls, Meetings, & Events

- Special Open Door Forum: Suggested Electronic Clinical Template for Lower Limb Prostheses.

Announcements and Reminders

- FY 2014 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities.
- CMS Finalizes Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit.
- Streamlined Access to PECOS, EHR, and NPPES – Coming Soon.
- Seeking Nominations for Physician Compare Quality Measurement Technical Expert Panel – August 22 Deadline.
- CMS Announces Teaching Hospital Closures and Round 6 of Section 5506 of the Affordable Care Act.
- CMS Hospital Quality Activities.
- EHR Incentive Programs: Review New FAQs on HIE and Public Health Measure Requirements for Meaningful Use.
- Have You Checked Your Patient's Immunization Status?

Claims, Pricer, and Code Updates

- Medicare to Adjust ESRD Home Dialysis Claims to Correct Network Reduction.
- FAQs about Incarcerated Beneficiary Claims Denials Now Available.
- 2014 GEMS Now Available.

MLN Educational Products Update

- "Incorrect Number of Units Billed for Rituximab (HCPCS J9310) and Bevacizumab (HCPCS C9257 and J9035) – Dose versus Units Billed" MLN Matters® Article – Revised.

AUGUST 15, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-15-Enews.pdf.

MLN Connects™ National Provider Calls

- ICD-10 Basics – Register Now.
- Did You Miss This MLN Connects™ Call?

MLN Educational Products Update

- "Quick Reference Chart: Short & Long Descriptors for Therapy Functional Reporting G-codes." Educational Tool – Released

- "Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens" Fact Sheet – Revised.
- "Hospital Value Based Purchasing Program" Fact Sheet – Revised.
- "Health Care Professional Frequently Used Web Pages" (Educational Tool) – Now Available in Electronic Publication Format.
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet.
- "ICD-10-CM Classification Enhancements" Fact Sheet.
- "General Equivalence Mappings Frequently Asked Questions" Booklet.
- "Mobile Apps for the OPEN PAYMENTS Program (Physician Payments Sunshine Act)" MLN Matters® Article – Released.

Announcements, Events, and Reminders

- OPEN PAYMENTS Program News.
- OPEN PAYMENTS Training Modules for Providers.
- Seeking Nominations for Physician Compare Quality Measurement Technical Expert Panel – August 22 Deadline.
- Prepare for Upcoming CMS Physician Quality Reporting System (PQRS) Program Milestones.

Claims, Pricer, and Code Updates

- CMS Furnishes Final List of Off-The-Shelf Orthotic HCPCS Codes.
- Erroneous Rejection of Outpatient Hospital Claims for SNF Consolidated Billing.
- Inpatient Prospective Payment System PC Pricer Updated.

AUGUST 22, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-22-eNews.pdf.

MLN Connects™ National Provider Calls

- Did You Miss These MLN Connects Calls?

MLN Educational Products Update

- "Guidance for Correct Claims Submission When Secondary Payers Are Involved" MLN Matters® Article – Reminder.
- "Quick Reference Chart: Short & Long Descriptors for Therapy Functional Reporting G-codes" Educational Tool – Released.
- New MLN Educational Web Guides Fast Fact.
- New MLN Provider Compliance Fast Fact.
- "A Physician's Guide to Medicare Part D Medication Therapy Management Programs" Podcast – Reminder.
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Podcast – Reminder.
- "Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training" Web-Based Training Course - Reminder.

Announcements, Events, and Reminders

- CMS Rule 1599-F: Inpatient Hospital Admission and Medical Review Criteria (2-Midnight Provision) and Part B Inpatient Billing in Hospitals.
- Transitioning to ICD-10 Video Slideshows Now Available.
- OPEN PAYMENTS Website - New Resources Now Available.
- OPEN PAYMENTS Notice: Public Comments Due September 20.

- Looking for Your 2012 PQRS Feedback Reports?
- 2012 eRx Incentive Program Feedback Reports Are Now Available.
- Opportunity for Provider Input on LTCH Quality Reporting Program.
- New Materials Available on Hospice Quality Reporting Program Website.
- CMS to Release a Comparative Billing Report on Home Health Services – Target Release August 29.
- Replacement of Home Oxygen Services in the Event that a Supplier Exits the Medicare Oxygen Business.
- **Reminder:** LTCH/IRF 1st Quarter Quality Data Due Friday August 23.
- Seeking Nominations for Physician Compare Quality Measurement Technical Expert Panel – Deadline Extended to September 3.
- CMS Announces Teaching Hospital Closures and Round 6 of Section 5506 of the Affordable Care Act.

AUGUST 29, 2013: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-29-eNews.pdf.

MLN Connects™ National Provider Calls

- Program Year 2012 Quality and Resource Use Reports – Mapping a Route to Success for the 2015 Value-Based Payment Modifier – Registration Now Open.
- Did You Miss These MLN Connects Calls?

MLN Connects™ Videos

- ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project.

MLN Educational Products Update

- "Open Payments: An Overview for Physicians and Teaching Hospitals" MLN Matters® Article – Released.
- "Transitional Care Management Services" Fact Sheet – Released.
- "Medicare Dependent Hospital" Fact Sheet – Now Available in Electronic Publication Format.
- "General Equivalence Mappings Frequently Asked Questions" Booklet – Revised.

Announcements, Events, and Reminders

- Healthy Aging – It's a Lifestyle Approach.
- New Data Show Antipsychotic Drug Use is Down in Nursing Homes Nationwide.
- Program Year 2012 QRURs for Group Practices Are Coming.
- PV-PQRS Registration is Still Open.
- Submit Suggestions for Advanced Diagnostic Imaging Program.
- Opportunity for Provider Input on the IRF Quality Reporting Program.
- Learn how to Participate in the 2013 PQRS-Medicare EHR Incentive Pilot.
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines.

Claims, Pricer, and Code Updates

- FISS DDE Will Not be Available on Saturday, August 31.
- Reason Codes for Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers' Compensation Medicare Secondary Payer Claims.

SEPTEMBER 5, 2013: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-05-enews.pdf.

MLN Connects™ National Provider Calls

- Program Year 2012 Quality and Resource Use Reports – Mapping a Route to Success for the 2015 Value-Based Payment Modifier – Register Now.

MLN Educational Products Update

- Fall 2013 Version of "The Medicare Learning Network® Catalog" – Now Available.
- "ICD-10-CM Classification Enhancements" Fact Sheet – Revised.
- "Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised.

Announcements, Events, and Reminders

- CDC Letter to Providers: Recommending Flu Vaccination for the 2013-14 Season.
- New Materials Available for Hospital Outpatient Prospective Payment System Proposed Rule.
- Steps to Avoid Negative Payment Adjustments under PQRS and Value Modifier.
- Opportunity for Provider Input on the Hospice Quality Reporting Program.
- Learn More About Submitting Quality Data for the EHR Incentive Programs for 2013.
- New and Updated FAQs for the EHR Incentive Programs Now Available.

Claims, Pricer, and Code Updates

- October 2013 Average Sales Price Files Now Available.

SEPTEMBER 12, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-12-Enews.pdf.

MLN Connects™ National Provider Calls

- Program Year 2012 Quality and Resource Use Reports - Mapping a Route to Success for the 2015 Value-Based Payment Modifier – Register Now.
- Did You Miss This MLN Connects Call?

MLN Educational Products Update

- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet – Reminder.
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet – Reminder.
- Four MLN Publications Now Available in Electronic Publication Format.

Announcements, Events, and Reminders

- Influenza Season is Almost Here.
- ICD-9-CM Coordination and Maintenance Committee Meeting.
- Sign Up for New CMS PQRS Listserv for Program Updates and Helpful Resources.
- Streamlined Access to PECOS, EHR, and NPPES – Coming Soon.
- Physician Groups of 100 or More: 4 Weeks Left to Register for PV- PQRS to Avoid a -1.0% Payment Adjustment.
- Skilled Nursing Facilities to Receive PEPPER.
- Spotlight on the Electronic Prescribing Measure for Stage 1 Meaningful Use.

Claims, Pricer, and Code Updates

- CMS-1500 Claim Form Updates: Medicare to Accept Revised Form Starting January 2014.

SEPTEMBER 19, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-19-enews.pdf.

MLN Connects™ National Provider Calls

- Program Year 2012 Quality and Resource Use Reports – Mapping a Route to Success for the 2015. Value-Based Payment Modifier – Last Chance to Register.
- MLN Connects Series on the Medicare and Medicaid EHR Incentive Programs – Audio and Transcripts Available.

MLN Educational Products Update

- "Additional Reporting Requirements Concerning Physician Ownership and Investment in Hospitals" MLN Matters® Article – Released.
- "Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims" MLN Matters® Article – Released.
- "Influenza Vaccine Payment Allowances – Annual Update for 2013-2014 Season" MLN Matters® Article – Released.
- "Same Day Billing for Mental Health Services and Primary Care Services" Fact Sheet – Released.
- "The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet – Reminder.
- "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet – Reminder.

Announcements, Events, and Reminders

- Help Your Medicare Patients Learn Their Blood Cholesterol Risk Level.
- Program Year 2012 QRURs for Group Practices Are Here.
- EHR Hospital Reporting for 2013 Ends on September 30: Begin Preparing for Attestation.

Claims, Pricer, and Code Updates

- Part B Medicare Ophthalmology Code Denial.
- FY 2012 Inpatient PPS PC Pricer Updated.

SEPTEMBER 26, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-26-final.pdf.

Announcements

- Registration for MAC Satisfaction Indicator Closing September 30.
- Influenza Season is Almost Here.
- CMS Proposes a Medicare Prospective Payment System for Federally Qualified Health Centers.
- Preventing and Detecting Potential Fraud in the Health Insurance Marketplace.
- Steps to the Avoid the 2015 PQRS Negative Payment Adjustments for Individuals and Group Practices with 2-99 EPs.
- Physician Groups of 100 or More: 2 Weeks Left to Register for PV- PQRS to Avoid a -1% Payment Adjustment.
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines.
- New Online ICD-10 Implementation Guide.
- EHR Hospital Reporting for 2013 Ends September 30: Begin Preparing for Attestation Today.
- Stage 2 Guide for the EHR Incentive Programs Now Available.
- New White Paper Reveals 57,000 EPs and 800 Eligible Hospitals Met and Successfully Attested to Stage 1 Meaningful Use in 2011.
- New Eligibility Fact Sheet Helps Health Care Professionals Determine eHealth Program Participation.
- New eHealth Interactive Tool Helps Determine Potential Upcoming Payment Adjustments.

MLN Educational Products Update

- New MLN Educational Web Guides Fast Fact.
- New MLN Provider Compliance Fast Fact.
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Reminder.

OCTOBER 24, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-26-final.pdf.

Announcements

- Registration for MAC Satisfaction Indicator Closing September 30.
- Influenza Season is Almost Here.
- CMS Proposes a Medicare Prospective Payment System for Federally Qualified Health Centers.
- Preventing and Detecting Potential Fraud in the Health Insurance Marketplace.
- Steps to the Avoid the 2015 PQRS Negative Payment Adjustments for Individuals and Group Practices with 2-99 EPs.
- Physician Groups of 100 or More: 2 Weeks Left to Register for PV- PQRS to Avoid a -1% Payment Adjustment.
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines.
- New Online ICD-10 Implementation Guide.
- EHR Hospital Reporting for 2013 Ends September 30: Begin Preparing for Attestation Today.
- Stage 2 Guide for the EHR Incentive Programs Now Available.
- New White Paper Reveals 57,000 EPs and 800 Eligible Hospitals Met and Successfully Attested to Stage 1 Meaningful Use in 2011.
- New Eligibility Fact Sheet Helps Health Care Professionals Determine eHealth Program Participation.
- New eHealth Interactive Tool Helps Determine Potential Upcoming Payment Adjustments.

MLN Educational Products Update

- New MLN Educational Web Guides Fast Fact.
- New MLN Provider Compliance Fast Fact.
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Reminder.

OCTOBER 31, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-10-31-enews.pdf.

MLN Connects™ National Provider Calls

- Streamlined Access to PECOS, EHR, and NPPES – Register Now.
- National Partnership to Improve Dementia Care in Nursing Homes – Registration Now Open.

Announcements

- National Breast Cancer Awareness Month.
- Payment Rules Notice.
- Proposed Quality Measures for EHR Incentive Program – Public Comments Due November 25.
- MEDCAC – Request for Nomination of Members.
- Therapy Services Functional Reporting FAQ Document Updated.
- Program Year 2012 QRURs for Group Practices Are Here.
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines.
- EHR Incentive Programs: Important Payment Adjustment Information for Medicare EPs.

- EHR Incentive Programs: Stage 1 Meaningful Use Calculator Includes Updated Measure Requirements.
- Learn How Your Eligible Hospital's EHR Participation Affects Upcoming Payment Adjustments.
- Create an ICD-10 Project Plan.

Claims, Pricers, and Codes

- ICD-10 MS-DRGs v31 Now Available.
- Release of 2014 PC Pricers.
- October 2013 Outpatient Prospective Payment System Pricer File Update.

MLN Educational Products

- "Post-Acute Transfer Processing Of CWF A/B Crossover Edit 7272 Update" MLN Matters® Article – Released.
- "2013-2014 Influenza (Flu) Resources for Health Care Professionals" MLN Matters® Article – Released.
- "September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" Fact Sheet – Released.
- New MLN Provider Compliance Fast Fact.
- MLN Products Available In Electronic Formats.
- "Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims" MLN Matters® Article – Revised.

NOVEMBER 7, 2013: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-07-enews.pdf.

MLN Connects™ National Provider Calls

- Streamlined Access to PECOS, EHR, and NPPES – Register Now.
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now.
- Did You Miss These MLN Connects Calls?

Announcements

- November is National Diabetes Month and Diabetic Eye Disease Month: November 14 is World Diabetes Day.
- Diabetes and Seasonal Influenza Vaccination.
- 2014 eRx Payment Adjustment Informal Review is Now Available.
- Access Your 2012 PQRS Feedback Report Today.
- How to Avoid the 2015 Payment Adjustments for PQRS.
- Reporting Period for EPs Participating in EHR Incentive Programs Ends December 31,
- Hospitals Must Attest by November 30 to Receive Payment for 2013 EHR Incentive Program Participation.
- New and Updated FAQs for the EHR Incentive Programs Now Available.

Thursday, October 17, 2013

MLN Connects™ National Provider Calls

Streamlined Access to PECOS, EHR, and NPPES — Save the Date

Announcements

Prevent and Control Seasonal Influenza with Vaccination
2013 PQRS Interim Feedback Dashboard Data is Now Available
Program Year 2012 QRURs for Group Practices Are Here
Learn How Your Eligible Hospital's EHR Participation Affects Upcoming Payment Adjustments
Check Out New Tools and Resources from Health IT Week

Claims, Pricers, and Codes

Delay in 2013 ESRD PC Pricer for Claims Effective October 1, 2012 and/or January 1, 2013
October 2013 CCI Edits for Physicians, Version 19.3 — Corrected File Posted

MLN Educational Products

"Expanded Coverage Under the Affordable Care Act: Information for Health Care Professionals" Fact Sheet — Released
"Medicare Enrollment and Claim Submission Guidelines" Booklet — Revised

MLN Connects™ National Provider Calls

Streamlined Access to PECOS, EHR, and NPPES — Save the Date

Friday, November 15; 2-3:30 ET

Registration Information: Coming soon to MLN Connects™ Upcoming Calls.

Target Audience: All Medicare FFS providers, as well as Professionals and Hospitals eligible for the Medicaid Electronic Health Record (EHR) Incentive Program

Changes have been made to simplify the way providers and suppliers access the Provider Enrollment Chain and Ownership System (PECOS), the EHR Incentive Program, and the National Plan and Provider Enumeration System (NPPES). These updates, available since October 7, improve the user experience when registering as an individual practitioner, authorized or delegated official of an organization, or someone working within PECOS on behalf of a

provider or supplier (also known as a surrogate). This MLN Connects Call will provide detailed instructions on these changes.

The new process will:

- Allow registered users to manage and reset their user ID and password online without calling a CMS Help Desk.
- Provide a simple and secure way for providers and suppliers to authorize individuals or groups of individuals to act on their behalf in PECOS and EHR.
- Allow designated authorized officials already on file with Medicare to be quickly approved to access PECOS without the need to submit documentation to CMS for verification prior to submitting the application.
- Allow organizations with potentially large numbers of credentialing or support staff to manage staff access to the various functions.
- Increase security to reduce the risk of provider identity theft and unauthorized access to systems.

Important Note: If you already have a user ID and password from NPPES, or currently access PECOS, NPPES, and/or EHR, your accounts will not be affected by this change. You can continue to use your established user ID and password to access the systems.

Agenda:

- Opening remarks
- Access Changes for PECOS, EHR, NPPES
- Question and Answer Session

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

Announcements

Prevent and Control Seasonal Influenza with Vaccination

Do you know if your patients are protected against influenza and pneumonia? Last flu season, people 65 years and older accounted for approximately 50% of reported hospitalizations resulting from influenza and related complications. The Centers for Disease Control and Prevention states that influenza vaccination is especially important for protecting those at highest risk for severe flu-related complications, such as adults 65 years and older and people with certain chronic health conditions. Use every patient visit as an opportunity to encourage influenza and pneumococcal vaccinations. Vaccinate your patients before flu activity picks up and continue to vaccinate patients throughout the flu season, which can last as late as May.

Generally, Medicare Part B covers one influenza vaccination and its administration per influenza season for Medicare beneficiaries without co-pay or deductible. Medicare generally covers the pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries. Medicare may provide coverage of additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status.

Note: The influenza and pneumococcal vaccines and their administrations are covered under Medicare Part B. Influenza and pneumococcal vaccines are *not* Part D-covered drugs.

For more information on coverage and billing of the influenza virus vaccine and its administration, please visit:

- CMS Medicare Learning Network® Preventive Services Educational Products and CMS Immunizations web pages (Check back for CMS 2013-2014 influenza season updates — coming soon to these web pages).
- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season."

- While some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. HealthMap Vaccine Finder is a free, online service where users can search for locations offering flu and other adult vaccines.

2013 PQRS Interim Feedback Dashboard Data is Now Available

Looking for 2013 PQRS Interim Claims Feedback?
Individual eligible professionals (EPs) who reported at least one 2013 Physician Quality Reporting System (PQRS) quality-data code (QDC) via *claims* can now access the Dashboard online tool to view 2013 quarter 1 (January through March) data regarding their submissions. The Dashboard is available through the Physician and Other Health Care Professionals Quality Reporting Portal (Portal), with Individuals Authorized Access to the CMS Computer Services (IACS) sign-in.

The Dashboard allows end users to immediately view current interim data through the website. This online tool will analyze data for those EPs who reported individual measures or measures group(s) and can be viewed as a Taxpayer Identification Number (TIN) summary or as individual National Provider Identifier (NPI) detail. EPs can access their 2013 PQRS data in order to monitor the status of claims-based individual measures and measures group reporting to determine whether they will meet requirements to earn the 2013 PQRS incentive payment and/or avoid the 2015 PQRS payment adjustment. *Please note:* The Dashboard will *not* email data to the requestor. See the Dashboard User Guide for additional information on the types of data available.

Need More Information?
The following CMS resources are available to help EPs and group practices access and interpret their 2013 PQRS interim feedback dashboard data:

- The User Guide: 2013 Interim Feedback Dashboard provides detailed information about accessing and interpreting the data provided in the feedback report.
- IACS Quick Reference Guides are available on the Portal and provide step-by-step instructions on how to request an IACS account in order to access the Portal, if you do not already have one.

Questions?
For all other questions related to PQRS, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

Program Year 2012 QRURs for Group Practices Are Here

Program Year 2012 Quality and Resource Use Reports (QRURs) are available for group practices with 25 or more eligible professionals (EPs). Authorized representatives of groups can access the QRURs at https://portal.cms.gov, using an Individuals Authorized Access to the CMS Computer Services (IACS) account with one of the following group-specific Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System roles:

- Primary PV-PQRS Group Security Official
- Backup PV-PQRS Group Security Official
- PV-PQRS Group Representative

We strongly encourage representatives of groups to sign up for a new IACS account or modify an existing account at https://applications.cms.hhs.gov as soon as possible in order to be able to access the QRURs. A Quick Reference Guide that provides instructions on how to obtain your 2012 QRUR is available in the "Downloads" section of the How to Obtain the 2012 QRUR web page.

Learn How Your Eligible Hospital's EHR Participation Affects Upcoming Payment Adjustments

Subsection (d) hospitals that are eligible to participate in the Medicare EHR Incentive Program must meet meaningful use requirements to avoid the federally-mandated payment adjustments that begin in FY 2015. The adjustment is determined by the hospital's reporting period in a prior year. Find out how your hospital's participation start year will affect its 2015 payment adjustments:

For Hospitals that Began Participation in 2011 or 2012:
Eligible hospitals that first demonstrated meaningful use in FY 2011 or 2012 must demonstrate meaningful use for a full year in FY 2013 to avoid payment adjustments in 2015. This data must be submitted via attestation by *November 30, 2013.*

For Hospitals that Begin Participation in 2013:
Eligible hospitals that first demonstrate meaningful use in FY 2013 must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid payment adjustments in 2015. This data must be submitted via attestation by *November 30, 2013.*

For Hospitals that will Begin Participation in 2014:
Eligible hospitals that first demonstrate meaningful use in FY 2014 must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first nine months of FY 2014 (i.e. they must begin the 90-day reporting period by April 1), and hospitals must attest to meaningful use no later than July 1, 2014, in order to avoid the payment adjustments.

Avoiding Payment Adjustments in the Future
Once hospitals begin participation in the Medicare EHR Incentive Program, they must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

For more information on timing and how to avoid payment adjustments, view the Payment Adjustment and Hardship Exemptions Tipsheet for Eligible Hospitals and Critical Access Hospitals.

Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Check Out New Tools and Resources from Health IT Week

To mark the third-annual National Health IT Week held September 16-20, CMS released new eHealth resources and blogs, and conducted a series of webinars to help providers participate in eHealth programs.

The new resources released include:

- An interactive eHealth timeline that highlights key 2013 and 2014 milestones to guide participation in the eHealth programs.
- An eHealth eligibility chart that will help health care professionals determine eligibility for eHealth programs.
- An interactive eHealth Payment Adjustment tool to help eligible professionals (EPs) determine if they will incur payment adjustments for the Medicare and Medicaid Electronic Health Record (EHR) Incentve Programs, Electronic Prescribing (eRx) Incentive Program, and the Physician Quality Reporting System.

CMS also posted a white paper with 2011 data of the EHR Incentive Programs. Highlights from the data include:

- 10% of all Medicare EPs and 17 % of eligible hospitals met and successfully attested to demonstrating meaningful use for Stage 1.
- No eligible hospitals were unsuccessful in attesting to meaningful use.

Webinars
The PowerPoint presentations from the two webinars that CMS hosted are posted on the Resources page of the eHealth website.

Want more information about CMS eHealth?
Make sure to visit the eHealth website for the latest news and updates.

Claims, Pricers, and Codes

Delay in 2013 ESRD PC Pricer for Claims Effective October 1, 2012 and/or January 1, 2013

Please be advised that CMS anticipates a delay for the FY 2013 ESRD PC Pricer release. CMS is in the process of transitioning to new software products to support the back-end development of all of the PC Pricers. This transition is expected to increase the initial development time. Executable files will be made available once the transition is complete, sometime between July 1 and October 31, 2013.

October 2013 CCI Edits for Physicians, Version 19.3 — Corrected File Posted

The Correct Coding Initiative (CCI) edit files for physicians have 2 parts. The correct Part 2 file for October 1, 2013 is now available on the NCCI Coding Edits web page.

MLN Educational Products

"Expanded Coverage Under the Affordable Care Act: Information for Health Care Professionals" Fact Sheet — Released

The "Expanded Coverage Under the Affordable Care Act: Information for Health Care Professionals" Fact Sheet (ICN 908826) was released and is now available in downloadable format. This fact sheet is designed to provide education on the Health Insurance Marketplace under the Affordable Care Act. It includes information health care professionals need to know about the Marketplace, an explanation of how the Affordable Care Act expands access to health coverage, and an explanation of the Marketplace, how it affects health care professionals and their patients, and resources.

"Medicare Enrollment and Claim Submission Guidelines" Booklet — Revised

The "Medicare Enrollment and Claim Submission Guidelines" Booklet (ICN 906764) was revised and is now available in hard copy format. This booklet is designed to provide education on applying for enrollment and submitting claims to Medicare. It includes the following information: enrolling in the Medicare Program; private contracts with Medicare beneficiaries; Medicare claims; deductibles, coinsurance, and copayments; Beneficiary Notices of Noncoverage; and billing requirements. To access a new or revised product available for order in *hard copy* format, go to MLN Products and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

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DMEPOS Contract Suppliers Announced

CMS has announced the contract suppliers for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. A list of Round 1 Recompete contract supplier locations for each product category and competitive bidding area is now available at www.dmecompetitivebid.com/cs. This list is current as of October 31, 2013. Contract suppliers may add or change locations. Updates will be posted on the Medicare Supplier Directory website at www.medicare.gov/supplier in mid-December 2013.

CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 1 Rebid contracts will expire on December 31, 2013, and the Round 1 Recompete contracts and prices are scheduled to go into effect on January 1, 2014.

For more information, view the Fact Sheet.

Overpayments on PMD Rentals in Round 2 Competitive Bidding Areas

Due to a system issue, certain rental claims for power mobility devices (PMDs) being rented by beneficiaries in Round 2 Competitive Bidding Areas (CBAs) have been paid by the DME MACs at a higher rate than should have been allowed per the Competitive Bidding Program.

Specifically, PMD claims that meet the following criteria have been overpaid:

- The claim is for a beneficiary who resides in a Round 2 CBA.
- The claim completed processing on or after July 1, 2013.
- The claim is billed with the KJ modifier (rental months 4–13).
- The claim is for one of the following HCPCS codes:

K0813	K0862	K0841	K0815	K0852
K0816	K0868	K0848	K0821	K0855
K0822	K0871	K0851	K0824	K0858
K0825	K0879	K0854	K0827	K0861
K0828	K0885	K0857	K0830	K0864
K0831	K0891	K0860	K0836	K0870
K0837	K0814	K0863	K0839	K0878
K0840	K0820	K0863	K0842	K0884
K0843	K0823	K0869	K0830	K0890
K0850	K0826	K0877	K0836	
K053	K0829	K0880	K0839	
K0856	K0834	K0886	K0842	
K0859	K0838	K0898	K0849	

Noridian will be adjusting any claims that meet the above criteria in order to correct the payment amount. As a result, if any claims meet these criteria, suppliers will receive an overpayment notification for the claims.

Quarterly Update for DMEPOS Competitive Bidding Program – January 2014

MLN Matters® Number: MM8434
Related Change Request (CR) #: CR 8434
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2793CP
Implementation Date: January 6, 2014
Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8434 to provide the DMEPOS Competitive Bidding Program (CBP) January 2014 quarterly update. Change Request (CR) 8434 provides specific instructions for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

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

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

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

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

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

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

Additional Information

The official instruction, CR8434 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2793CP.pdf on the CMS website.

Documentation for Supply Refills Required with Appeal and Other Requests for Documentation

When submitting appeal requests for DMEPOS items supplied as refills, the records regarding refills and proof of delivery, as outlined below, must be submitted. This also applies to other requests for documentation.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order.

Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items 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 and must verify with the ordering physician that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one- or three-month quantity at a time.

There must be sufficient, specific and credible information regarding the quantity the beneficiary still has remaining to be able to determine that the quantity was actually assessed and will be approaching exhaustion on the delivery date, as required by the CMS Program Integrity Manual, Chapter 5, Section 5.2.6.

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

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

- Beneficiary's name or authorized representative if different than the beneficiary.
- A description of each item that is being requested.
- Date of refill request.
- Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date.

As stated in 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 on the specifically recorded date.

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.

DOCUMENTATION

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:

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.

Physician Documentation Responsibilities

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

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

DRUGS AND BIOLOGICALS

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

Current Review Results

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

- The J7507 review involved 3,601 claims, of which 2,765 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 71%.
- The J7517 review involved 2,226 claims, of which 1,716 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.
- The J7518 review involved 2,037 claims, of which 1,502 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 70%.
- The J7520 review involved 59 claims, of which 47 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 69%.

Primary Documentation Errors that Resulted in Denial of Claims

There was 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.

There were no refill requirements submitted or the refill requirements submitted were invalid.

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 [hereinafter pim108c5, §5.2.5]) and pim108c5, §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 1-month quantity at a time (clm104c17, §80.3).

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

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

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

There was no proof of delivery or the proof of delivery submitted was invalid.

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

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

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

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

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary.

Method 1–Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

There was no detailed written or dispensing order submitted.

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

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.

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).

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

Going Forward

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

Education Resources

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

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

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

EDUCATIONAL

DME on Demand - A Tool to Gain Knowledge on DME Topics

Noridian would like to announce our new self-paced education tools called DME on Demand. A DME on Demand is a self-paced presentation, varying in length, which allows viewers an opportunity to listen to presentations at their convenience. Numerous DME on Demand presentations are now posted which cover topics varying from general to policy-specific topics. The purpose of DME on Demands is to provide a brief overview on specified topics. Topics may also be broken into numerous presentations to pinpoint areas of interest to suppliers so please watch for multiple presentations for one topic with detailed titles about content. These presentations can be found on our website at https://www.noridianmedicare.com/dme/train/education_tools.html. Refer to the Local Coverage Determinations (LCDs), related Policy Articles and Supplier Manual for additional information about coverage and documentation requirements.

General

- Advance Beneficiary Notice of Noncoverage.
- Before You Bill.
- Certificate of Medical Necessity and DME Information Form.
- CMS 1500 Claim Form.
- Continued Use/Continued Need.
- Modifiers:
  - AU, AV, AW.
  - RT/LT.
- Email List.
- New Detailed Written Order and Face-to-Face Requirements.
- DMEPOS Place of Service.
- Prior Authorization of Power Mobility Devices (PMDs).
- Proof of Delivery.
- Repairs and Replacements.
- Request for Refills.
- Types of Order.

Policy-Specific

- Ankle-Foot/Knee-Ankle-Foot Orthosis.
- Commodes.
- Enteral Nutrition.
  - Administration.
  - Billing.
  - Coding.
  - Coverage Criteria.
  - Documentation.
- External Breast Prosthesis.
- High Frequency Chest Wall Oscillation Devices.
- Indwelling Catheters: Coverage Criteria.
- Intermittent Catheterization: Coverage Criteria.
- Manual Wheelchair Bases.
- Negative Pressure Wound Therapy: Ulcer Definitions.
- Oral Anticancer/Antiemetic Drugs.
- Oxygen.
- Positive Airway Pressure Devices: Continued Coverage After 3rd Month.
- PMDs: Documentation.
- Power Operated Vehicles: Coverage Criteria.
- Refractive Lenses.
- Seat Lift Mechanisms.
- Speech Language Pathologist Evaluation for Speech Generating Devices.
- Speech Generating Devices.
- Suction Pumps.
- Tracheostomy Care or Cleaning Starter Kits.
- Tracheostomy Care Supplies.
- Transcutaneous Electrical Nerve Stimulators (TENS).

In-Person Seminar Feedback

Noridian would like to ask for your feedback on our in-person seminars. We have created a survey for suppliers to provide us feedback on how we can improve our in-person education. We are consistently trying to ensure our seminars meet the needs of our suppliers.

Please take a minute to complete this quick and easy survey. It will assist our education staff in future planning of these seminars. We look forward to hearing from you and thank you in advance for any suggestions you may provide!

In-Person Seminar Survey

EDUCATIONAL

Request an Electronic Supplier Visit

A new form has been added to our website for suppliers to request individual education. Electronic supplier visits provide the opportunity for one-on-one, web-based training with Noridian's education staff. Fill out the form titled Education Request found on our website under the Training and Events tab and your request will be e-mailed to staff that will follow-up with you regarding scheduling an electronic supplier visit.

Each request for education will be evaluated by our staff and does not guarantee individual training. Suppliers are still encouraged to attend our web-based workshops and in-person seminars as well as contacting our Supplier Contact Center at 877-320-0390 for individual questions.

Please be as specific as possible when filling out the form; PHI must not be included.

ENTERAL NUTRITION

Joint DME MAC Article: Documentation & Billing Reminders for Enteral Nutrition Claims

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have identified a growing trend in Comprehensive Error Rate Testing (CERT) errors for Enteral Nutrition related items. Suppliers are reminded of §1833(e) of the Social Security Act which 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 may 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 made available upon request from any auditing Medicare contractor.

Detailed Written Orders

The detailed written order (DWO) for enteral nutrition is required prior to claim submission. The Medicare program allows for someone other than the ordering physician to create/produce the DWO. However the ordering physician must review the content of the DWO and sign and date it. The DWO must contain the following elements:

- 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.

Failure to secure a DWO with the required elements indicated will render the order incomplete and result in an error and refund request.

Clinical Records Documentation

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions. 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.

Enteral nutrition is covered for a beneficiary who has one of the following:

- Permanent non-function or disease of the structures that normally permit food to reach the small bowel.
- Disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the beneficiary's overall health status.

When one of these two requirements is met, the Medicare program will reimburse for the nutrients, supply kits and the enteral nutrition pump when needed. The most common error relating to the clinical record documentation for enteral nutrition is the failure to show that the medical necessity is met as outlined in the medical policy. Suppliers are responsible for securing clinical record information that clearly documents the beneficiary's condition.

Nutrients

When the coverage criteria is met for the enteral nutrition therapy, the enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150 or B4152) are deemed appropriate for the majority of beneficiaries requiring enteral nutrition.

If the patient exhibits intolerance to any semi-synthetic formula, the medical record must reflect the unfavorable events that resulted in the prescribing of the special enteral formula (B4149, B4153-B4155, B4157, B4161, and B4162). If a special enteral nutrition formula is provided and if the medical record does not document why that item is medically necessary, it will be denied as not reasonable and necessary.

Continued Medical Need

In addition to establishing the initial need for enteral nutrition, the clinical records may also be used to support continued medical need. Use of the clinical record to support continued medical need for the nutrients, supplies and equipment must be timely. Per the LCD requirements for continued medical need, the clinical documentation must be within the preceding 12 months of the date of service under review. Suppliers are not limited to the clinical record to support continued medical need and may use any of the following documents, in lieu of the clinical record to support that the items remain reasonable and necessary.

- A recent order by the treating physician for refills.
- A recent change in prescription.
- A properly completed CMN or DIF with an appropriate length of need specified.

Signature Requirements

These guidelines apply not only to claims reviewed by the durable medical equipment Medicare administrative contractor (DME MAC), but also to claims reviewed by the Comprehensive Error Rate Testing (CERT) contractor, program safeguard contractor (PSC), and recovery audit contractor (RAC). For medical review purposes, Medicare requires that all orders and medical records that are used in the adjudication of claims be authenticated by the author. The method used must be a legible handwritten full signature, handwritten initials, or electronic signature. Those requirements are published in the CMS Internet-Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.1

Durable Medical Equipment Information Form (DIF)

Enteral nutrition is an item that requires a DIF. A valid DIF is one in which the supplier has attested to and signed supporting the medical need for the item. When the DME MACs, DME PSCs, and ZPICs identify a claim for which a DIF is not valid, they may deny the claim and/or initiate overpayment action. Suppliers are required to complete the DIF including their signature prior to claim submission. If the DIF is used to verify that statutory benefit requirements have been met, then the claim will be denied as not meeting the benefit category. Therefore, it is imperative that suppliers complete the DIF accurately to ensure that claims are adjudicated appropriately. For complete details concerning the completion of the DIF form, please consult the CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, §5.3.

This article is only a summary of the Enteral Nutrition coverage and documentation requirements. Suppliers should read the entire Enteral Nutrition Local Coverage Determination and related Policy Article for additional coverage, coding and documentation requirements.

Physician Letter – CERT Enteral Nutrition

September 19, 2013

CERT Enteral Nutrition

Dear Physician:

The Comprehensive Error Rate Testing (CERT) Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), performs medical review audits for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries to determine the paid claims error rate for Medicare contractors and providers.

The CERT Contractor may request that your patient's supplier obtain information from you in order to verify that Medicare coverage criteria have been met in dispensing the item(s) ordered by you. The supplier must submit the documentation to CERT within 30 days from the date of his/her receipt of the initial request letter. Failure to respond to the CERT's request for documentation will result in an error and recoupment of the paid claim.

Medicare covers Enteral Nutrition under the Prosthetic Device Benefit as established by the Social Security Act §1862 (a)(8). Please refer to the Local Coverage Determination (LCD) on Enteral Nutrition, the related Policy Article and the Supplier Manual for additional information about coverage, billing and documentation requirements. You may access the Enteral Nutrition LCD on the CMS website under the Medicare Coverage Database.

Your patient's medical record must contain sufficient information about his/her medical condition to substantiate that the applicable Medicare coverage criteria have been met. This information must justify the type of enteral nutrient ordered by you, how it is administered and the frequency of feedings. Also, as for all orders written by you for DMEPOS items for your Medicare patients, you are responsible for completing a detailed written order for each item. The detailed order requirements are also listed within the Enteral Nutrition LCD.

The most common CERT error related to clinical record documentation for Enteral Nutrition is the failure to show that the patient initially met the coverage criteria. Another frequent CERT error is the failure to establish the medical need for the patient to stay on Enteral Nutrition ("continued medical need"). To validate this, the supplier may use the physician's clinical record showing that the physician made an indication of this within the preceding 12 months of the date of service being reviewed.

DMEPOS suppliers are your partners in caring for your patient. They will not receive payment from Medicare for the items that are ordered for your patient if you do not provide information from your medical record when it is requested. Furthermore, if you do not provide this information to the supplier for this audit, your patient may have to pay for the item. Finally, your cooperation is a legal requirement as outlined in the Social Security Act which is the law governing Medicare.

Please do not send medical records that your supplier requests from you directly to the DME MAC, but rather return them to him or her. Also, please remember that you may not charge the supplier or the beneficiary to provide this information. Help your DMEPOS supplier continue to provide the highest quality of service to your patient by promptly providing the information from your medical record that is requested.

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

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

Current Review Results

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

- The B4154 review involved claims, of which 660 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.

Primary Documentation Errors that Resulted in Denial of Claims

19% of B4154 claims received a denial as no refill documentation was provided or the documentation provided was invalid.

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

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

12% of B4154 claims received a denial as the proof of delivery was invalid.

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

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

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

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

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary.

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

8% of B4154 claims received a denial as the physician order was incomplete or was missing elements.

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

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

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

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

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

7% of B4154 claims received a denial as no documentation was received.

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

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Enteral Nutrition Local Coverage Determination (LCD) L11568 and Policy Article A25361. Suppliers can also review specific policy resources for Enteral Nutrition on the Noridian website located at https://www.noridianmedicare.com/dme/news/ enteral_nutrition.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

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

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

Results of Widespread Prepayment Probe Review of Enteral Nutrition (HCPCS B4150)

Review Results

Jurisdiction D, DME MAC, Medical Review Department completed a widespread prepayment probe review of HCPCS codes B4150. This review was initiated based on on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The B4150 review involved 197 claims, of which 179 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.

Primary Documentation Errors that Resulted in Denial of Claims

20% of B4150 claims received a denial as no refill requirement documentation was provided or the refill requirement documentation was invalid.

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

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

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

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

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

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

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

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

13% of B4150 claims received a denial as no documentation was received.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §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.

10% of B4150 claims received a denial as the detailed written order submitted had incomplete or missing elements.

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

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

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

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

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

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

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

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

The dispensing order must be available upon request.

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

14% of B4150 claims received a denial as the proof of delivery submitted was invalid.

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

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

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

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

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary.

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS codes B4150.

GLUCOSE MONITORS

Coverage Reminder – Safety Lancets Non-covered

Questions about Medicare coverage of safety lancets used in assisted living facilities have recently arisen. Safety Lancets are devices used to obtain samples for conducting blood glucose monitoring. They are safety-engineered with features designed to safeguard users from blood-borne pathogens. The DME MACs have been told that Occupational Safety and Health Administration (OSHA) regulations require that residential settings, such as group homes or assisted living facilities, provide lancets with safety-engineered features in order to safeguard their employees.

Safety lancets are considered to be precautionary items (i.e. they are necessary for the safety of the user when assisting a patient in using a home blood glucose monitor) and are not covered regardless of the setting or who is making use of them. Safety lancets are not needed in order to avoid an adverse medical outcome on the beneficiary who requires the test and are therefore not needed for the beneficiary's personal home blood glucose monitor to function. Services provided in group homes, assisted living facilities, and other similar residential facilities that furnish personal assistance or custodial care are not covered by Medicare. The cost of furnishing safety lancets in order to safeguard employees is part of the cost of providing assisted living services and is the responsibility of the facility. DMEPOS suppliers are not required to furnish safety lancets under Medicare payment rules since these items fall outside the scope of the DME benefit.

Refer to the Glucose Monitors Local Coverage Determination and the related Policy Article for additional information.

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code A4253. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from June 1, 2013 through August 31, 2013, resulted in an overall error rate of 67%.

Primary Documentation Errors that Resulted in Denial of Claims

The requested documentation was not received by the contractor within the allotted timeframe.

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

The refill requirements were not met.

For services performed prior to 11/01/12 – The beneficiary has nearly exhausted the supply of test strips and lancets, or useful life of one lens shield cartridge previously dispensed.

For services performed on or after 11/01/12 – For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products (A4233–A4236, A4253, A4256, A4258 and A4259) that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6).

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

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

The documentation submitted did not support the actual testing frequency that corroborates the quantity of supplies that were dispensed.

For services performed prior to 11/01/12 – If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

For services performed on or after 11/01/12 – (Criteria c for high utilization)- If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

The order submitted was invalid.

DISPENSING ORDERS (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

- Item(s) to be dispensed.
- Dosage or concentration, if applicable.
- Route of Administration.

- Frequency of use.
- Duration of infusion, if applicable.
- Quantity to be dispensed.
- Number of refills, if applicable.

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

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

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

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

The DWO must be available upon request.

Going Forward

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

Education Resources

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

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

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

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

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

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

Quarterly Results of Widespread Prepayment Review of Claims for Blood Glucose Test or Reagent Strips HCPCS A4253

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A4253. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

- The A4253 review involved 4,183 claims, of which 4,098 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 94%.

Primary Documentation Errors that Resulted in Denial of Claims.

17% of A4253KS claims received a denial as documentation does not support the actual testing frequency that corroborates with quantity of supplies that have been dispensed.

For services performed on or after 11/01/12-(Criterion c for high utilization)- If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

14% of A4253KS claims received a denial as no documentation was received.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §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.

13% of A4253KS claims received a denial as the medical records do not support the specific reason for the additional materials for the particular beneficiary.

For services performed on or after 11/01/12-(Criterion b for high utilization)- The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary.

11% of A4253KS claims received a denial as the refill requirements have not been met.

For services performed on or after 11/01/12-For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products (A4233-A4236, A4253, A4256, A4258 and A4259) that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6).

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

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

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.
- Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date.

- 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.

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Glucose Monitors on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/glucose_monitors.html.There; you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

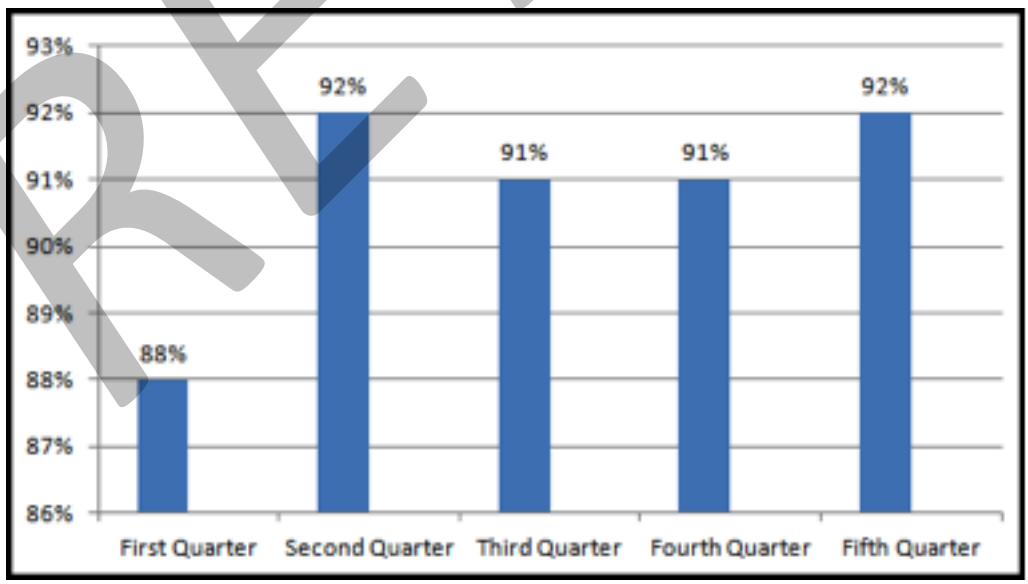
Fifth Quarter Results of Widespread Prepayment Review of Claims for Hospital Beds (HCPCS E0260)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0260. The fourth quarter edit effectiveness results from April 2013 through July 2013 are as follows:

- The E0260 review involved 2,300 claims of which 2,082 were denied. This resulted in an overall error rate of 92%.

Historical Data of the Error Rate for E0260 Review



HOSPITAL BEDS

Primary Documentation Errors that Resulted in Denial of Claims

- 22% of E0260 claims received a denial as the medical documentation submitted did not support the criteria for a fixed height bed.
- 22% of E0260 claims received a denial as the medical documentation submitted did not support the criteria for a semi-electric bed.

Per LCD L11572, a fixed height hospital bed is covered if one or more of the following criteria (1–4) are met:

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

A semi-electric hospital bed is covered if the patient meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

- 15% of E0260 claims received a denial as no documentation was provided in response to the additional documentation request.
- 7% of E0260 claims received a denial as no medical records were provided.

Per LCD L11572, section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due to such provider". It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request. An order for each item billed must be signed and dated by the treating physician, kept on files by the supplier, and be available upon request.

Going Forward

Based on high error rate, Noridian will continue with the Prepayment Widespread Review.

ICD-10

Display of ICD-10 LCDs on the MCD

MLN Matters® Number: MM8348
Related Change Request (CR) #: CR8348
Related CR Release Date: September 6, 2013
Effective Date: October 7, 2013
Related CR Transmittal #: R12930TN
Implementation Date: April 10, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8348 which is issued by the Centers for Medicare & Medicaid Services (CMS) to ensure that International Classification of Diseases, Tenth Revision (ICD-10) LCDs and articles are published in the Medicare Coverage Database (MCD) in a timely manner to allow providers sufficient time to make provider specific billing system changes. Make sure that your billing staff is aware of these changes.

Background

CR 8348 instructs that all ICD-10 LCDs and associated ICD-10 articles will be published on the Medicare Coverage Database (MCD) no later than April 10, 2014. All other LCDs and articles (i.e., those LCDs and articles that do not contain ICD-10 information, or articles not attached to an LCD) will be published on the MCD no later than September 4, 2014.

Note: All LCDs and Articles will receive a new LCD/Article ID number. For example, LCD ID 1234 might become LCD ID 4567.

The new LCD/Article ID number could have an impact on MACs local systems, such as changing their Medicare Summary Notice to capture the new LCD/Article ID number.

CMS has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies will not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their Carrier Advisory Committee or be sent through the public comment and notice process.

However, if a MAC decides to revise more than just the ICD-10 code(s), they will follow the normal LCD development process outlined in the "Medicare Program Integrity Manual" (Publication 100-08, Chapter 13 (Local Coverage Determinations)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf on the CMS website.

Additional Information

The official instruction, CR 8348 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1293OTN.pdf on the CMS website.

LCD AND POLICY ARTICLE REVISIONS

LCD and PA Revisions Summary

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

AUGUST 29, 2013

Manual Wheelchair Bases

LCD

Revision Effective Date: 10/01/2013
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: K0008
Added: E1037 – E1039 and K0008 coverage criteria
HCPCS CODES:
Added: E1037 – E1039 and K0008
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: K0008 to ADMC eligible
Added: E1037 – E1039 and K0008 requirements

Policy Article

Revision Effective Date: 10/01/2013
CODING GUIDELINES:
Added: K0008 description and reference
Removed: K0108 billing method for wheelchair modification

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 05/29/2013 (August 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Coverage for use with alemtuzumab, azacitidine, bendamustine, carboplatin, clofarabine, cytarabine, daunorubicin, idarubicin, ifosfamide, irinotecan and oxaliplatin

Power Mobility Devices

LCD

Revision Effective Date: 10/01/2013
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Clarification of need for WOPD
Added: K0013 under general coverage criteria
HCPCS Codes:
Added: K0013
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: K0013 documentation requirements
MISCELLANEOUS:
Added: K0013 to ADMC eligible

Policy Article

Revision Effective Date: 10/01/2013
CODING GUIDELINES:
Added: K0013 customized motorized/power wheelchair verbiage
MISCELLANEOUS:
Added: K0013 is not subject to PDAC code verification

OCTOBER 31, 2013

Urological Supplies

LCD

Revision Effective Date: 12/15/2013
HCPCS CODES:
Added: GA and GZ modifiers
DOCUMENTATION REQUIREMENTS:
Added: Instructions for GA and GZ modifiers when R&N criteria are not met

Policy Article

Revision Effective Date: 12/15/2013
CODING GUIDELINES:
Revised: A4353 definition to include sterile "no-touch" catheter systems

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

LCD AND POLICY ARTICLE REVISIONS

Policy Update – TENS (E0720, E0730) Additional KX Modifier Requirements and CMN Requirement Reinstated for Chronic Low back Pain Diagnosis

In the recent revision of the TENS LCD (effective 06/08/2012), the CMN requirement was removed for claims associated with chronic low back pain (CLBP) diagnoses. The requirement had been removed to simplify the documentation requirements for this group. The removal of the requirement for this subset of claims caused denials at CWF. To resolve these denials the CMN requirement for TENS (E0720, E0730) is reinstated for CLBP effective for claims with dates of service on or after 10/01/2013.

Please note this revision of the LCD also requires use of the KX modifier for HCPCS codes E0720 and E0730 (in addition to code E0731) when any one of the coverage criteria, I-III, in the Coverage Indications, Limitations and/or Medical Necessity section are met.

Additionally, the ASSOCIATED INFORMATION section of the LCD and the NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related policy article for TENS has been updated to include face to face encounter requirements as outlined in Section 6407 of the Affordable Care Act.

Refer to the TENS LCD and related Policy Article for additional information.

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. Please review the entire LCD and each related PA for complete information.

MOBILITY DEVICES

Denial for PMD Claim from Supplier DMEPOS When Ordered By Non-Authorized Provider

MLN Matters® Number: MM8239
Related Change Request (CR) #: CR 8239
Related CR Release Date: November 6, 2013
Effective Date: April 1, 2014
Related CR Transmittal #: R1305OTN
Implementation Date: April 7, 2014

Provider Types Affected

This MLN Matters® Article is intended for suppliers of Durable Medical Equipment (DME) who submit claims to DME Medicare Administrative Contractors (DME/MACs) for Power Mobility Devices (PMDs) provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8239 instructs Medicare contractors and system maintainers to implement edits to deny claims for certain PMDs if the ordering/referring provider is not on Medicare's list of providers eligible to order/refer these PMDs.

Make sure that your billing staffs are aware of these requirements and you do not order if you are not an authorized provider. Suppliers are required to ascertain that the provider is authorized to order a PMD A denial of the claim will be issued if the provider is not of an authorized specialty to order a PMD.

Background

Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), added Section 1834(a)(1)(E)(iv) to the Act which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in section 1861(r)(1) of the Act), or a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) (as these terms are defined in Section 1861(aa)(5) of the Act) has conducted a face-to-face examination of the beneficiary and written a prescription for the item. This purpose of CR 8239 is to create an edit to deny any DMEPOS claims where the ordering/prescribing provider is not an eligible provider (physician, PA, NP, or CNS).

The following are the policies/definitions that impact Medicare allowances for PMDs:

1. **Social Security Act Section 1834(a)(1)(E)(iv) standards for power wheelchairs;**
   Effective on the date of the enactment of this subparagraph in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in Section 1861(r)(1)), a PA, NP or CNS (as those terms are defined in Section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.
2. **Social Security Act Section 1861(r)(1)**
   The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)).
3. **Social Security Act Section 1861(aa)(5)**
   The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a PA or NP who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

   The term "clinical nurse specialist" means, for purposes of this title, an individual who is a registered nurse and is licensed to practice nursing in the State in which the CNS services are performed; and holds a master's degree in a defined clinical area of nursing from an accredited educational institution.
4. **Based on 42 CFR Part 410.38(c), the following definitions apply:**

   PMD means a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

Key Points of CR8239

The list of specified covered, PMD items: HCPCS Code and Description includes the following:

- K0800-K0808 and K0812: ALL POWER OPERATED VEHICLES.
- K0813-K0891, K0898: POWER WHEELCHAIRS.
- K0013: CUSTOM MOTORIZED/ POWER WHEELCHAIR BASE.

The list of authorized physician specialties and their corresponding CMS specialty code in Provider Enrollment, Chain, and Ownership System (PECOS) is as follows:

Medicare PECOS

CODE	APPROVED PHYSICAN SPECIALTIES
01	GENERAL PRACTICE
02	GENERAL SURGERY
03	ALLERGY/IMMUNOLOGY
04	OTOLARYNGOLOGY
05	ANESTHESIOLOGY
06	CARDIOVASCULAR DISEASE (CARDIOLOGY)
07	DERMATOLOGY
08	FAMILY PRACTICE
09	INTERVENTIONAL PAIN MANAGEMENT
10	GASTROENTEROLOGY
11	INTERNAL MEDICINE

CODE	APPROVED PHYSICAN SPECIALTIES
12	OSTEOPATHIC MANUPULATIVE MEDICINE
13	NEUROLOGY
14	NEUROSURGERY
16	OBSTETRICS/GYNECOLOGY
17	HOSPICE/PALLIATIVE CARE
18	OPHTHALMOLOGY
20	ORTHOPEDIC SURGERY
21	CARDIAC ELECTROPHYSIOLOGY
22	PATHOLOGY
23	SPORTS MEDICINE
24	PLASTIC AND RECONSTRUCTIVE SURGERY
25	PHYSICAL MEDICINE AND REHABILITATION
26	PSYCHIATRY
27	GERIATRIC PSYCHIATRY
28	COLORECTAL SURGERY (PROCTOLOGY)
29	PULMONARY DISEASE
30	DIAGNOSTIC RADIOLOGY
33	THORACIC SURGERY
34	UROLOGY
36	NUCLEAR MEDICINE
37	PEDIATRIC MEDICINE
38	GERIATRIC MEDICINE
39	NEPHROLOGY
40	HAND SURGERY
44	INFECTIOUS DISEASE
46	ENDOCRINOLOGY
66	RHEUMATOLOGY
72	PAIN MANAGEMENT
76	PERIPHERAL VASCULAR DISEASE
77	VASCULAR SURGERY
78	CARDIAC SURGERY
79	ADDICTION MEDICINE
81	CRITICAL CARE (INTENSIVISTS)
82	HEMATOLOGY
83	HEMATOLOGY/ONCOLOGY
84	PREVENTATIVE MEDICINE
85	MAXILLOFACIAL SURGERY
86	NEUROPSYCHIATRY
90	MEDICAL ONCOLOGY
91	SURGICAL ONCOLOGY
92	RADIATION ONCOLOGY

CODE	APPROVED PHYSICAN SPECIALTIES
93	EMERGENCY MEDICINE
94	INTERVENTIONAL RADIOLOGY
98	GYNECOLOGICAL ONCOLOGY
C0	SLEEP LABORATORY/MEDICINE

The list of authorized non-physician specialties and their corresponding CMS specialty code in PECOS is as follows:

PECOS is as follows: CODE	APPROVED NON-PHYSICIAN SDPECIALTY
50	NURSE PRACTITIONER
89	CLINICAL NURSE SPECIALIST
97	PHYSICIAN ASSISTANT

Suppliers are required to ascertain that the provider is authorized to order a PMD. A list of providers authorized to order a PMD can be accessed (beginning April 2014) at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website.

A denial of the claim will be issued if the provider is not on the PECOS list. Be aware that all of the criteria for coverage of PMDs must be met.

When a claim for a relevant PMD is denied because the ordering/referring provider was ineligible to place the order, Medicare will use the a Claim Adjustment Reason Code of 183 (The Referring Provider is not eligible to refer the service billed) and a Remittance Advice Remarks Code of N574 (Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer).

Additional Information

The official instruction, CR 8239, issued to your DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1305OTN.pdf on the CMS website.

For a look at face-to-face requirements and a checklist you may review SE1112, "Power Mobility Device Face-to-Face Examination Checklist" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1112.pdf on the CMS website.

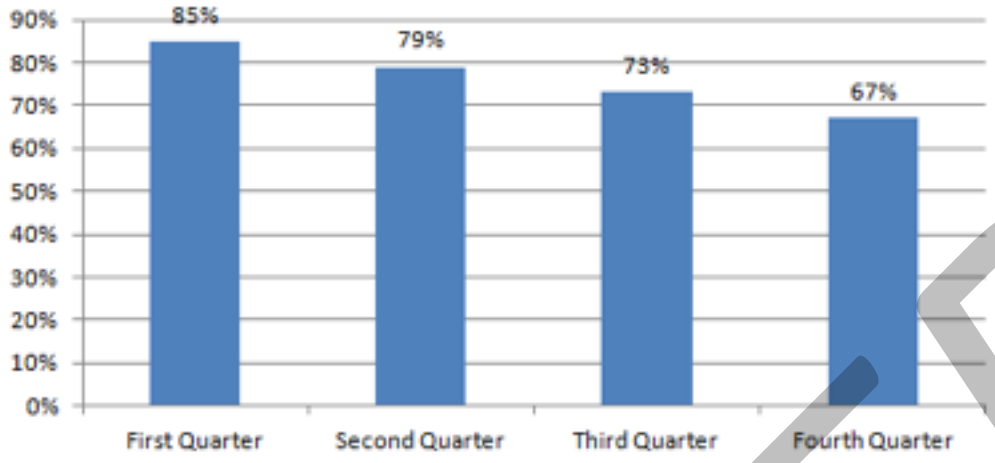
Fourth Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0822)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code K0822. The fourth quarter edit effectiveness results from April 23, 2013 through July 22, 2013 are as follows:

- The K0822 review involved 34 claims, of which 25 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

Historical Data of the Error Rate for K0822 Review



Primary Documentation Errors that Resulted in Denial of Claims

23.21% of K0822 claims received a denial as the documentation did not support that an optimally-configured manual wheelchair was insufficient.

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.

17.86% of K0822 claims received a denial as the face-to-face examination was incomplete or missing elements.

LCD L23598 states, "The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History of the present condition(s) and past medical history that is relevant to mobility needs:

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

Physical examination that is relevant to mobility needs:

- Weight and height.
- Cardiopulmonary examination.
- Musculoskeletal examination.
  - Arm and leg strength and range of motion.
- Neurological examination.
  - Gait.
  - Balance and coordination.

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

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

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

14.29% of K0822 claims received a denial for the order being incomplete or missing elements.

7-Element Orders (PIM 5.9.2)

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

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

The Supplier may provide a template order listing the seven required elements but is prohibited from completing any part of it. The treating physician completing the face-to-face requirements must write the 7-element order. The 7-element order may only be written after the completion of the face-to-face exam requirements. Refer to the Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information regarding the statutory requirements for PMDs.

A date stamp or equivalent must be used to document receipt date.

10.71% of K0823 claims received a denial as there was no detailed product description or the detailed product description submitted was invalid.

Per LCD L23598, "Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

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

Going Forward

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

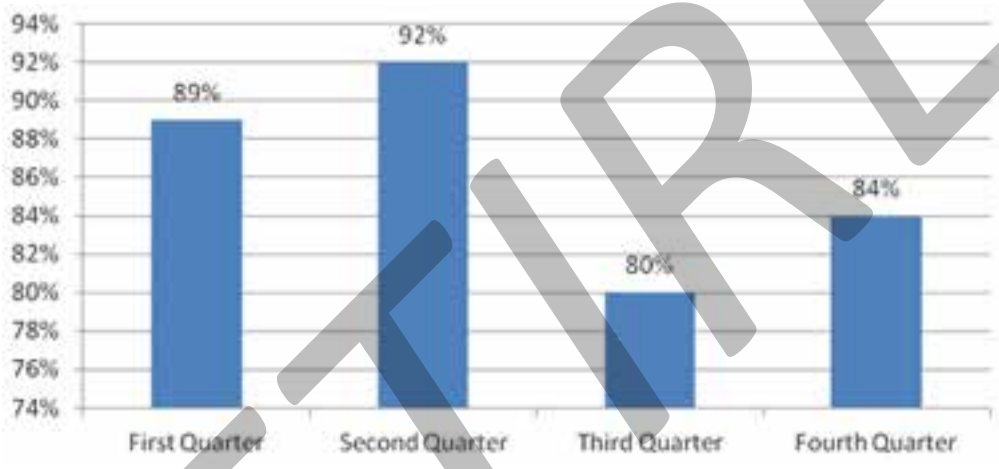
Fourth Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0825)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code K0825. The first quarter edit effectiveness results from April 23, 2013 through July 22, 2013 are as follows:

- The K0825 review involved 66 claims, of which 55 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 84%.

Historical Data of the Error Rate for K0825 Review



Primary Documentation Errors that Resulted in Denial of Claims

31.09% of K0825 claims received a denial as the documentation did not support that an optimally-configured manual wheelchair was insufficient.

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.

10.92% of K0825 claims received a denial as the documentation did not support that a power operated vehicle was insufficient.

The beneficiary's medical records do not support the beneficiary does not meet coverage criterion D. The beneficiary is able to:

- Safely transfer to and from a POV.
- Operate the tiller steering system.
- Maintain postural stability and position while operating the POV in the home.

10.08% of K0823 claims received a denial as the face-to-face examination was incomplete or missing elements.

LCD L23598 states, "The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History of the present condition(s) and past medical history that is relevant to mobility needs:

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

Physical examination that is relevant to mobility needs:

- Weight and height.
- Cardiopulmonary examination.
- Musculoskeletal examination.
  - Arm and leg strength and range of motion.
- Neurological examination.
  - Gait.
  - Balance and coordination.

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

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

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

10.08% of K0825 claims received a denial as no documentation was received.

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

Going Forward

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

Power Mobility Devices Local Coverage Determination – Update

The Power Mobility Devices Local Coverage Determination (LCD) has been revised to remove the Written Order Priority to Delivery standard language.

This clarification has been incorporated with the current policy effective for dates of service on or after October 1, 2013.

Refer to the Power Mobility LCD and Policy Article for complete information concerning coverage criteria, coding guidelines, and documentation requirements.

Quarterly Edit Effectiveness Results of Widespread Prepayment Review of Claims for Power Mobility Devices

Review Result

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment review of billed power mobility devices when a change in medical need had been indicated. This review was initiated based on internal data analysis and prior review results.

This case opened March 27, 2013 with the first quarter ending June 26, 2013. Six claims have been reviewed. Two of these claims were denied. A final findings article will be posted upon completion of claim review.

Going Forward

Going forward, Noridian will close this widespread review.

Quarterly Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0823 and All Related Accessories)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0823 and all related accessories. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

- The K0823 review involved 372 claims, of which 248 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 66%.

Primary Documentation Errors that Resulted in Denial of Claims

26.75% of K0823 claims received a denial as 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.

13.10% of K0823 claims received a denial as there was no detailed product description or the detailed product description submitted was invalid.

Per LCD L23598, "Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

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

11.62% of K0823 claims received a denial as the face-to-face examination was incomplete or missing elements.

LCD L23598 states, "The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History of the present condition(s) and past medical history that is relevant to mobility needs:

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

Physical examination that is relevant to mobility needs:

- Weight and height.
- Cardiopulmonary examination
- Musculoskeletal examination.
    - Arm and leg strength and range of motion.
- Neurological examination.
    - Gait.
    - Balance and coordination.

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

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

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

7.93% of K0823 claims received a denial as the documentation does not support the beneficiary's mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker.

The beneficiary's medical records do 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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127: https://www.noridianmedicare.com/dme/coverage/lcd.html.

Suppliers can also review specific policy resources for Power Mobility Devices on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

Quarterly Results of Widespread Prepayment Review of Claims for Manual Wheelchairs (HCPCS K0001, K0003 and K0004)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003 and K0004. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

- The K0001 review involved 1050 claims, of which 977 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 92%.
- The K0003 review involved 732 claims, of which 696 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 92%.
- The K0004 review involved 439 claims, of which 413 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.

Primary Documentation Errors that Resulted in Denial of Claims:

- 20% of K0001 claims received a denial for an invalid or missing home assessment.
- 16% of K0003 claims received a denial for an invalid or missing home assessment.
- 16% of K0004 claims received a denial for an invalid or missing home assessment.

Documentation must support Criterion C: The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

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

- 17% of K0001 claims received a denial regarding the resolution of the beneficiary's mobility limitations with a cane or walker.

- 12% of K0003 claims received a denial regarding the resolution of the beneficiary's mobility limitations with a cane or walker.
- 10% of K0004 claims received a denial regarding the resolution of the beneficiary's mobility limitations with a cane or walker.

The documentation must support Criterion B: The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

- 11% of K0003 claims received a denial as the requested documentation was not received.
- 16% of K0004 claims received a denial as the requested documentation was not received.

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

- 21% of K0003 claims received a denial as medical records do not support the beneficiary requires a lightweight wheelchair.
- 20% of K0004 claims received a denial as medical records do not support the beneficiary requires a high strength lightweight wheelchair (K0004).

A lightweight wheelchair (K0003) is covered when the documentation supports that the beneficiary meets both criteria:

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

A high strength lightweight wheelchair (K0004) is covered when the documentation supports that the beneficiary meets criteria (1) or (2):

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

- 11% of K0001 claims received a denial regarding the beneficiary's mobility limitation impairment to mobility-related activities of daily living (MRADLs).

Documentation provided must support Criterion A: The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing an MRADL entirely.
2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

- 11% of K0001 received a denial regarding improvement of MRADLs with wheelchair use.

The documentation must support Criterion D: Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Manual Wheelchair Bases Local Coverage Determination (LCD) L11454 and Policy Article A25378.

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

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

Walker Unbundling Billing for Brakes

The DME MACs have recently identified an unbundling issue related to walkers (E0141, E0143, and E0149) and brake attachments (E0159). This article provides clarification on when it is appropriate to bill the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) separately for walkers and brake attachments.

Upon initial issue of an E0141, E0143, and E0149, if brakes are being provided at the same time, the charges are included in the reimbursement for the walker and may not be billed separately to the DME MACs or the beneficiary. The following table can be found in the Walkers policy article; please note the status of the brake attachments (E0159):

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time and must not be billed separately at the time of billing the Column I code.

Column I	Column II
E0130	A4636, A4637
E0135	A4636, A4637
E0140	A4636, A4637, E0155, E0159
E0141	A4636, A4637, E0155, E0159
E0143	A4636, A4637, E0155, E0159
E0144	A4636, A4637, E0155, E0156, E0159
E0147	A4636, E0155, E0159
E0148	A4636, A4637
E0149	A4636, A4637, E0155, E0159

Below is a reference regarding each HCPCS code and narrative description for the above table:

A4636	REPLACEMENT, HANDGRIP, CANE, CRUTCH, OR WALKER, EACH
A4637	REPLACEMENT, TIP, CANE, CRUTCH, WALKER, EACH.
E0130	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0135	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0140	WALKER, WITH TRUNK SUPPORT, ADJUSTABLE OR FIXED HEIGHT, ANY TYPE
E0141	WALKER, RIGID, WHEELED, ADJUSTABLE OR FIXED HEIGHT
E0143	WALKER, FOLDING, WHEELED, ADJUSTABLE OR FIXED HEIGHT
E0144	WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE
E0148	WALKER, HEAVY DUTY, WITHOUT WHEELS, RIGID OR FOLDING, ANY TYPE, EACH
E0149	WALKER, HEAVY DUTY, WHEELED, RIGID OR FOLDING, ANY TYPE
E0155	WHEEL ATTACHMENT, RIGID PICK-UP WALKER, PER PAIR
E0159	BRAKE ATTACHMENT FOR WHEELED WALKER, REPLACEMENT, EACH

Note: HCPCS code E0159 (Brake attachment for wheeled walker, replacement each) is applicable for replacement brakes ONLY.

An Advance Beneficiary Notice of Noncoverage (ABN) should not be executed to shift financial liability to the beneficiary for brakes provided at the same time the walker is dispensed.

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

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

NEBULIZERS

Billing Reminder: Nebulizers – Pharmacy Dispensing Fees for Inhalation Drugs

Recent reviews of Nebulizers and inhalation drugs have identified incorrect billing for inhalation drug dispensing fees. This article will review the billing requirements.

An initial dispensing fee (G0333) is payable to a pharmacy for the initial 30 day supply of covered inhalation drug(s) regardless of the number of drugs dispensed, the number of shipments, or the number of pharmacies used by the beneficiary during that time. This initial 30-day dispensing fee is a once in a lifetime fee and only applies to beneficiaries who are using inhalation drugs for the first time as a Medicare beneficiary on or after 01/01/2006.

If code G0333 is billed for a 30 day supply of covered inhalation drugs and it is not the initial 30 day supply (i.e., G0333 has already been billed to Medicare for that beneficiary), the claim will be denied as incorrect coding.

When code G0333 has been billed once in a beneficiary's lifetime, subsequent claims for a 30 day dispensing fee must be billed using code Q0513.

Medicare will only pay for one of the following for covered inhalation drugs regardless of the number of drugs dispensed, the number of shipments, or the number of pharmacies used by the beneficiary during that time period-an initial dispensing fee (G0333), a 30 day dispensing fee (Q0513), or a 90 day dispensing fee (Q0514).

For a refill prescription, payment of a dispensing fee will be allowed no sooner than 7 days before the end of usage for the current 30 day or 90 day period for which a dispensing fee was previously paid. Medicare will not pay for more than 12 months of dispensing fees per beneficiary per 12 month period.

If the dispensing fee is billed sooner than the interval specified above, it will be denied as not separately payable. For example, if a 90 day fee (Q0514) is billed on 1/30/06 and is covered and there is a subsequent claim for a 30 day fee (Q0513) on 4/20/06, the dispensing fee on 4/20/06 will be denied as not separately payable.

Both a Q0513 and a Q0514 dispensing fee are not covered on the same date of service.

If a supplier dispenses a 90 day supply of one drug and a 30 day supply of another drug on the same day, code Q0514 (90 day fee) must be billed.

The dispensing fee must be billed on the same claim as the inhalation drug(s). If it is not, it will be denied as incorrect billing.

A dispensing fee is not separately billable or payable for saline, whether used as a diluent or for humidification therapy.

Medicare will not pay for a separate fee for the compounding of inhalation drug(s).

Refer to the Nebulizer LCD, related Policy Article and Supplier manual for additional information about coverage, billing and documentation requirements.

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code J7605 and J7626. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from July 1, 2013 through September 31, 2013, resulted in an overall error rate of 28%.

Primary Documentation Errors that Resulted in Denial of Claims

The requested documentation was not received by the contractor within the allotted timeframe.

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

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

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

The refill requirements were not met.

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

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

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

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

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

The order submitted was invalid.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

- Item(s) to be dispensed.

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

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

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

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

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

The DWO must be available upon request.

Going Forward

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

Education Resources

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

Nebulizers

- Local Coverage Determination L11488.
- Policy Article A24942.

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

- Documentation Checklists: https://www.noridianmedicare.com/dme/coverage/docs/checklists/nebulizers_and_respiratory_drugs.html.
- Physician Resource Letters: https://www.noridianmedicare.com/dme/coverage/resources.html.

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

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

HCPCS L5981 – Notification of Widespread Prepayment Targeted Review

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

- L5981: All Lower Extremity Prostheses, Flex-Walk System or Equal.

Widespread prepayment targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on CERT review analysis and previous review 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 dispensing and written order.
- Documentation of dispensing order (if item is dispensed based on a dispensing order).
- Patient's medical records (physician medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) that support the item(s) provided are reasonable and necessary.
- Documentation to support the functional level modifier used.
- Continued medical need of the item.
- 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 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 Lower Limb Prostheses Local Coverage Determination (LCD) L11453 and Policy Article A25367.

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

Knee Orthoses Local Coverage Determination – Covered Diagnoses Update

The Knee Orthoses local coverage determination (LCD) has been revised with the addition of diagnosis 727.66, Rupture of tendon, nontraumatic, site-patellar tendon.

Effective for dates of service on or after August 15, 2013, ICD-9 code 727.66 is covered for HCPCS codes L1830, L1832, L1834, L1843, L1844, L1845, and L1846.

Refer to the Knee Orthoses LCD and Policy Article for complete information concerning coverage criteria, coding guidelines, and documentation requirements.

Quarterly Results of Widespread Prepayment Review of Claims for Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1970, L1960 and L4360)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code(s) L1970, L1960 and L4360. The quarterly edit effectiveness results from June, 2013 through September, 2013 are as follows:

- The L1970 review involved 244 claims, of which 207 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 84%.
- The L1960 review involved 278 claims, of which 237 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 88%.
- The L4360 review involved 1,516 claims, of which 1,323 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 87%.

Primary Documentation Errors that Resulted in Denial of Claims

Treating physician's records didn't provide detailed documentation to support medical necessity of a custom 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.

Criteria 1-5 were not met.

AFO's and KAFO's that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

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

Basic coverage criteria were not met.

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 detailed written order or dispensing order was provided.

All items billed to Medicare require a prescription. An order for each new or full replacement item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

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

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim. Detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name.
- Physician's name.
- Date of the order and start date, if start date different than date of order.
- Detailed description of the item(s).
- Physician signature and signature date.

Going Forward

Based on the high error rate, Noridian will continue with the Prepayment Widespread Review.

Education Resources

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

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

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

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

Quarterly Results of Widespread Prepayment Review of Claims for External Breast Prostheses (HCPCS L8030)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code L8030. The quarterly edit effectiveness results from July 2013 through September 2013 are as follows:

- The L8030 review involved 712 claims, of which 464 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 62%.

13% of L8030 claims received a denial as no office notes or medical records to support medical necessity were submitted.

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

Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

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

12% of L8030 claims received a denial as no documentation was received.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §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.

11% of L8030 claims received a denial for invalid proof of delivery.

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

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

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

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

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary.

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

8% of L8030 claims received a denial documentation did not support continued need.

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

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

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

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

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the External Breast Prostheses Local Coverage Determination (LCD) L11569 and Policy Article A19833.

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

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

Quarterly Results of Widespread Prepayment Review of Claims for Spinal Orthoses (HCPCS L0631 and L0637)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L0631 and L0637. The quarterly edit effectiveness results from July 2013 through September 2013 are as follows:

- The L0631 review involved 1,584 claims, of which 1,369 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 87%.
- The L0637 review involved 528 claims, of which 453 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 86%.

Primary Documentation Errors that Resulted in Denial of Claims

- 22% of L0631 claims received a denial as coverage criteria indicated in Spinal Orthoses LCD (L11459) was not met.
- 17% of L0637 claims received a denial as coverage criteria indicated in Spinal Orthoses LCD (L11459) was not met.

A thoracic-lumbar-sacral orthosis (L0450-L0492), lumbar orthosis (L0625-L0627) or lumbar-sacral orthosis (L0628-L0640) is covered when it is ordered for one of the following indications:

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

- 19% of L0631 claims received a denial as the proof of delivery provided was invalid.
- 20% of L0637 claims received a denial as the proof of delivery provided was invalid.

Proof of Delivery (PIM 4.26, 5.8)

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

- 17% of L0631 claims received a denial as the DME item does not have the required coding verification or unable to verify the DME item as being listed on the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site.
- 15% of L0637 claims received a denial as the DME item does not have the required coding verification or unable to verify the DME item as being listed on the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site.

Manufacturers and suppliers are reminded that a number of items require coding verification review by the Pricing, Data Analysis and Coding (PDAC) contractor. As noted in the Local Coverage Determinations (LCD) and related Policy Articles that include these codes, claims for these Healthcare Common Procedure Coding System (HCPCS) codes will be denied if the products requiring coding verification review are not listed on the PDAC Product Classification List. Coding decisions are updated frequently. Suppliers should refer to the Product Classification List often to ensure Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items billed have been coded by the PDAC. The Product Classification List is located on Durable Medical Equipment Coding System (DMECS) which is located on the PDAC website at: https://www.dmepdac.com/dmecs/index.html.

Effective for claims with dates of service on or after July 1, 2010, the only products that may be billed using codes, L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637, and L0639 for prefabricated orthoses are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site.

Effective for claims with dates of service on or after July 1, 2010, prefabricated spinal orthoses and spinal orthoses that are custom fabricated by a manufacturer/central fabrication facility which has not received coding verification review from the PDAC must be billed with code A9270.

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

- 8% of L0631 claims received a denial as no documentation was received in response to the additional documentation request.
- 11% of L0637 claims received a denial as no documentation was received in response to the additional documentation request.

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

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses Local Coverage Determination (LCD) L11459 (https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/spinal_orthoses_tlso_and_lso.htm) and Policy Article A23846 (https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/spinal_orthoses_tlso_and_lso.htm).

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

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

Results of Widespread Prepayment Probe Review of Lower Limb Prostheses (HCPCS L5980)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS code L5980. This review was initiated based on results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The L5980 review involved 95 claims, of which 76 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

Documentation did not support need for replacement.

Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following:

1. A change in the physiological condition of the beneficiary.
2. Irreparable wear of the device or a part of the device.
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.

Replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician's order when it is determined that the prosthesis as originally ordered still fills the beneficiary's medical needs.

No documentation was received.

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

Documentation did not support functional level being 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).
- The beneficiary's current condition including the status of the residual limb and the nature of other medical problems.
- The beneficiary's desire to ambulate.

Clinical assessments of beneficiary rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

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.

A lower limb prosthesis is covered when the beneficiary:

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

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS code L5980.

Education Resources

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

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

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

Results of Widespread Prepayment Probe Review of Lower Limb Prostheses (HCPCS L5981)

Review Results

Jurisdiction D, DME MAC, Medical Review Department completed a widespread prepayment probe review of HCPCS codes L5981. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The L5981 review involved 99 claims, of which 81 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 76%.

Primary Documentation Errors that Resulted in Denial of Claims

Documentation did not support functional level being 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).
- The beneficiary's current condition including the status of the residual limb and the nature of other medical problems.
- The beneficiary's desire to ambulate.

Clinical assessments of beneficiary rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

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.

A lower limb prosthesis is covered when the beneficiary:

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

Documentation did not support the beneficiary is motivated to ambulate.

A lower limb prosthesis is covered when the beneficiary:

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

Documentation did not support medical need for replacement.

Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following:

1. A change in the physiological condition of the beneficiary.
2. Irreparable wear of the device or a part of the device.
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.

Replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician's order when it is determined that the prosthesis as originally ordered still fills the beneficiary's medical needs.

Going Forward

Noridian will close this probe review.

Second Quarter Results of Widespread Prepayment Review of Claims for External Breast Prostheses (HCPCS L8030)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L8030. The first quarter edit effectiveness results from April 2013 through June 2013 are as follows:

- The L8030 review involved 743 claims of which 562 were denied. This resulted in an overall error rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

- 13% of L8030 claims received a denial as no office notes or medical records to support medical necessity were submitted.

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

Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

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

- 12% of L8030 claims received a denial as no documentation was received.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §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.

- 11% of L8030 claims received a denial for invalid proof of delivery.

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

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

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

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

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary.

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

- Beneficiary's name.
- Delivery address.

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

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

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

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

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

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

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

- 10% of L8030 claims received a denial as the order was incomplete or missing elements

Dispensing Orders (PIM 5.2.2)

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

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

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

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

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

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

The DWO must be available upon request.

Going Forward

Based on high error rate, Noridian will continue with the Prepayment Widespread Review.

Quarterly Review of Claims for Stationary and Portable Oxygen (E1390 and E0431)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E1390 with RA modifier and E0431 with RA modifier. The quarterly edit effectiveness results from March 2013 through September 2013 are as follows:

- The E1390 with RA modifier review involved 1,191 claims, of which 917 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 77%.
- The E0431 with RA modifier review involved 360 claims, of which 246 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

Primary Documentation Errors that Resulted in Denial of Claims

A blood gas study was not provided.

The blood gas study refers to either an oximetry test or an arterial blood gas test.

Group I criteria include any of the following:

1. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake).
2. An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a beneficiary who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake.

3. A decrease in arterial PO 2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia.
4. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the beneficiary was breathing room air.

Initial coverage for beneficiaries meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification.)

Group II criteria include the presence of

1. An arterial PO 2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least 5 minutes, or during exercise (as described under Group I criteria), and
2. Any of the following:
    - Dependent edema suggesting congestive heart failure.
    - Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF).
    - Erythrocythemia with a hematocrit greater than 56 percent.

Initial coverage for beneficiaries meeting Group II criteria is limited to 3 months or the physician specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification.)

Group III includes beneficiaries with arterial PO 2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these beneficiaries there is a rebuttable presumption of noncoverage.

If all of the coverage conditions specified above are not met, the oxygen therapy will be denied as not reasonable and necessary. Oxygen therapy will also be denied as not reasonable and necessary if any of the following conditions are present:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO 2 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

- The date of the physician's signature on the CMN/order is after the date of service on the claim and a verbal/dispensing order was not provided.

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.

Dispensing Orders (PIM 5.2.2)

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

- Description of the item.
- Beneficiary's name.

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

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

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

The DWO must be available upon request.

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

There was no documentation provided to support continued medical use.

Continued Use

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

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

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

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

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

There was no documentation provided to support continued medical need.

Continued Medical Need

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

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

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

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

Going Forward

Noridian will close this Prepayment Widespread Review.

Education Resources

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

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/oxygen_and_oxygen_equipment.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

Quarterly Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS E0439 and E0434)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0439 and E0434. The quarterly edit effectiveness results from July, 2013 through October, 2013 are as follows:

- The E0439 review involved 381 claims, of which 216 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 65%.
- The E0434 review involved 238 claims, of which 147 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 69%.

Primary Documentation Errors that Resulted in Denial of Claims

The date of the physician's signature on the CMN/order is after the date of service on the claim and a verbal/dispensing order was not provided.

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

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

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

The DWO must be available upon request.

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

The Proof of Delivery (POD) is prior to the date of service on the claim or the POD submitte is invalid.

Proof of Delivery (PIM 4.26, 5.8)

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

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

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

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

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

1. Delivery directly to the beneficiary or authorized representative.
2. Delivery via shipping or delivery service.
3. Delivery of items to a nursing facility on behalf of the beneficiary.

Method 1 – Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

Documentation was not provided to support that alternative treatment measures have been tried or considered and deemed clinically ineffective.

National Coverage Determination (NCD) for Home Use of Oxygen (240.2)

Section B – Medical Documentation

Initial claims for oxygen services must include a completed span Form CMS-484 (Certificate of Medical Necessity: Oxygen) to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription or other medical documentation. The treating physician's prescription or other medical documentation must indicate that other 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. While there is no substitute for oxygen therapy, each patient must receive optimum therapy before long-term home oxygen therapy is ordered. Use Form CMS-484 for recertifications. (See the Medicare Program Integrity Manual, Chapter 5, for completion of Form CMS-484.)

Documentation was not provided to support that the treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.

National Coverage Determination (NCD) for Home Use of Oxygen (240.2)

Section D – Health Conditions

Coverage is available for patients with significant hypoxemia in the chronic stable state if:

- The attending physician has determined that the patient has a health condition outlined in subsection D.1.
- The patient meets the blood gas evidence requirements specified in subsection D.3.
- The patient has appropriately tried other alternative treatment measures without complete success. (See subsection B).

1. **Conditions for Which Oxygen Therapy May Be Covered**

- A severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, whether of known or unknown etiology; cystic fibrosis, bronchiectasis; widespread pulmonary neoplasm.
- Hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy. Examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache.

2. **Conditions for Which Oxygen Therapy Is Not Covered**

- Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen use is sometimes prescribed to relieve this condition, it is potentially harmful and psychologically addicting.
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO 2 improves the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the lungs.
- A blood gas study was not provided.

The blood gas study refers to either an oximetry test or an arterial blood gas test.

Group I criteria include any of the following:

1. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake).
2. An arterial PO 2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a beneficiary who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake.

3. A decrease in arterial PO 2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia.
4. An arterial PO 2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial PO 2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the beneficiary was breathing room air.

Initial coverage for beneficiaries meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification).

Group II criteria include the presence of:

1. An arterial PO 2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least 5 minutes, or during exercise (as described under Group I criteria), and
2. Any of the following:

- Dependent edema suggesting congestive heart failure.
- Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF).
- Erythrocythemia with a hematocrit greater than 56 percent.

Initial coverage for beneficiaries meeting Group II criteria is limited to 3 months or the physician specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification.)

Group III includes beneficiaries with arterial PO 2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these beneficiaries there is a rebuttable presumption of noncoverage.

If all of the coverage conditions specified above are not met, the oxygen therapy will be denied as not reasonable and necessary. Oxygen therapy will also be denied as not reasonable and necessary if any of the following conditions are present:

- Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments.
- Dyspnea without cor pulmonale or evidence of hypoxemia.
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO 2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the respiratory system.

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/oxygen_and_oxygen_equipment.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

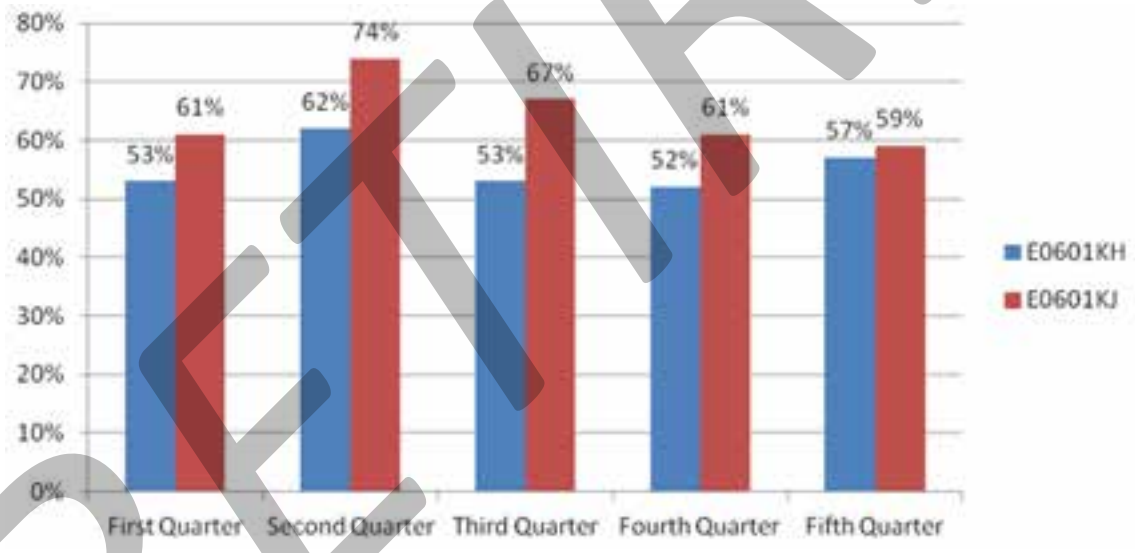
Fifth Quarter Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Devices (HCPCS E0601)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0601 for the first month of billing (KH modifier) and the 4th-13th month of billing (KJ modifier). The fifth quarter edit effectiveness results for KH modifier from April 27 2013 to July 25 2013 and for KJ modifier from May 16 2013 to August 3 2013 are as follows:

- The E0601(KH) review involved 1247 claims, of which 719 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 57%.
- The E0601(KJ) review involved 579 claims, of which 360 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 59%.

Historical Data of the Error Rate for E0601(KH) and E0601KJ Review



Primary Documentation Errors that Resulted in Denial of Claims

No documentation was received.

A large number of suppliers failed to respond to our request for records. Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

Documentation did not support Criteria A (face-to-face clinical evaluation) was met.

The patient must have a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea. (Criteria A of LCD L171)

Documentation did not support signature requirements were met.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author per PIM 3.3.2.4.

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

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

- Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved.

Going Forward

Based on high error rate, Noridian will continue with the Prepayment Widespread Review.

Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency Claims – Full Implementation of Edits – Fourth Revision

MLN Matters® Number: SE1305 Revised

This article was revised on November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the Advance Beneficiary Notice, CARC codes and DME rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same.

Note: This article was previously revised on April 19, 2013, to add references to the CMS-1450 form and to add question h. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, **please only include the first and last name as it appears on the ordering and referring file** found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.
- Part B providers and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral.
- Part A Home Health Agency (HHA) services who submit claims to Regional Home Health Intermediaries (RHHIs), Fiscal Intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

What Providers Need to Know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first letter of the first name and the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI). The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests.
- Claims from imaging centers for ordered imaging procedures.
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS.

- Claims from Part A Home Health Agencies (HHA).

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B).
- Physician Assistants.
- Clinical Nurse Specialists.
- Nurse Practitioners.
- Clinical Psychologists.
- Interns, Residents, and Fellows.
- Certified Nurse Midwives.
- Clinical Social Workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.

Questions and Answers Relating to the Edits

1. **What are the ordering and referring edits?**

   The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. **Why did Medicare implement these edits?**

   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. **How and when will these edits be implemented?**

   These edits were implemented in two phases:

Phase 1 – Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering provider name.
N265	Missing/incomplete/invalid ordering provider primary identifier.

For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	**Alert:** Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier.

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.[1]

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html; click on "Ordering & Referring Information" (on the left). Information about the Report will be displayed.

[1]NPIs were added only when the matching criteria verified the NPI.

Phase 2: Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

254D or 001L	Referring/Ordering Provider Not Allowed To Refer/Order.
255D or 002L	Referring/Ordering Provider Mismatch.

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

Below are the denial edits for Part A HHA providers who submit claims:

37236 This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33'. • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code.
37237 This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33'. • The type of bill frequency code is '7' or 'F-P'. • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.

Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

1. **You have a current Medicare enrollment record.**
   - If you are not sure you are enrolled in Medicare, you may:
     - Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI.
     - Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI.
     - Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
     - If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
2. **If you do not have an enrollment record in Medicare.**
   - You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
     - For paper applications – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
     - For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
     - In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.

- If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
- If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html).

3. **You are an opt-out physician and would like to order and refer services. What should you do?**

   If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

4. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.**

   When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

5. **I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?**

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.
- Ensure you are correctly spelling the Ordering/Referring Provider's name.
- If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits.
- The Ordering Referring Report will be replaced weekly to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report.

6. **Make sure your claims are properly completed.**

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the Ordering and Referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the Ordering/Referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.
- If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

- Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

7. **What if my claim is denied inappropriately?**

   If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through the standard claims appeals process.

8. **How will the technical vs. professional components of imaging services be affected by the edits?**

   Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

9. **Are the Phase 2 edits based on date of service or date of claim receipt?**

   The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

10. **A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?**

    Claims for capped rental items will continue to be paid for up to 13 months from the implementation date of the Phase 2 edits to allow coverage for the duration of the capped rental period.

Additional Guidance

- **Terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
- **Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.
- **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

- **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

For more information about the Medicare enrollment process, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf on the CMS website.

Note: You must obtain a National Provider Identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website. For more information about NPI enumeration, visit http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html on the CMS website.

MLN Matters® Article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf on the CMS website.

MLN Matters® Article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf on the CMS website.

MLN Matters® Article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf on the CMS website;

MLN Matters® Article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf on the CMS website.

MLN Matters Article, MM6856, "Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare Regional Home Health Intermediaries (RHHIs), is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf on the CMS website.

Ordering and Referring Denial Edits Will Be Implemented on January 6, 2014

CMS will instruct contractors to turn on Phase 2 denial edits on January 6, 2014. These edits will check the following claims for a valid individual National Provider Identifier (NPI) and deny the claim when this information is invalid:

- Claims from clinical laboratories for ordered tests.
- Claims from imaging centers for ordered imaging procedures.

- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS.
- Claims from Part A Home Health Agencies (HHAs).

For more information:

- MLN Matters® Article #SE1305, "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)".

Quarterly Results of Widespread Prepayment Review of Claims for Group 1 Pressure Reducing Support Surfaces (HCPCS E0181 and E0185)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS codes E0181 and E0185. The quarterly edit effectiveness results from April 2013 through July 2013 are as follows:

- The E0181 review involved 370 claims, of which 266 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.
- The E0185 review involved 315 claims, of which 248 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 77%.

Primary Documentation Errors that Resulted in Denial of Claims

No documentation was received in response to Additional Documentation Letters (ADR).

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

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:

1. The patient is completely immobile – i.e., patient cannot make changes in body position without assistance.
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.
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D.

- 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.

- Medical records did not support coverage criteria.

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.

Going Forward

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

Quarterly Results of Widespread Prepayment Review of Claims for Group 2 Pressure Reducing Support Surfaces (HCPCS E0277)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code E0277. The quarterly edit effectiveness results from April 2013 through July 2013 are as follows:

- The E0277 review involved 171 claims, of which 141 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 83%.

Primary Documentation Errors that Resulted in Denial of Claims

No documentation was received in response to Additional Documentation Letters (ADR).

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

Medical records did not support coverage criteria.

A group 2 support surface is covered if the beneficiary meets at least one of the following three Criteria (1, 2 or 3):

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

3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (ICD-9 707.02 -707.05), and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

Going Forward

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

REFILLS

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

REIMBURSEMENT

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

MLN Matters® Number: MM8448
Related Change Request (CR) #: CR 8448
Related CR Release Date: September 6, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2780CP
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8448 which instructs Medicare contractors to download and implement the January 2014 Average Sales Price (ASP) drug pricing files; and, if released by the Centers for Medicare & Medicaid Services (CMS), the October 2013, July 2013, April 2013, and January 2013 drug pricing files for Medicare Part B drugs.

Medicare will use the January 2014 ASP and Not Other Classified (NOC) drug pricing files to:

- Determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2014, with dates of service January 1, 2014, through March 31, 2014.
- Update the drug payment limits for claims for infusion drugs furnished through a covered item of DME processed or reprocessed on or after January 1, 2014, with dates of service on or after January 1, 2014.

Background

The Medicare Modernization Act of 2003 (MMA) Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost, or prospective payment, basis.

The Average Sales Price (ASP) methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS); who will quarterly supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the Medicare Claims Processing Manual, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER). You can find this manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website.

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

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

Please note that: 1) The ASP and NOC drug pricing files will contain the applicable payment allowance limits (i.e., 106% ASP, 106% Wholesale Acquisition Cost (WAC), or 95% Actual Wholesale Price (AWP)); and as a result, your Medicare contractor will not make any additional payment calculations; 2) For any drug or biological not listed in the ASP or NOC drug pricing files, your contractor will determine the payment allowance limits in accordance with the policy described in the Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Section 20.1.3 (Exceptions to Average Sales Price (ASP) Payment Methodology); which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf on the CMS website; and 3) Your MAC will seek payment allowances from their local carrier for drugs and biologicals that are not on the ASP file.

In addition, you should be aware that your MAC will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information

The official instruction, CR 8448, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2780CP.pdf on the CMS website.

Payment Rules Notice

Although we are still assessing the impact of the partial government shutdown on completion of the calendar year 2014 Medicare fee for service payment regulations, we intend to issue the final rules on or before November 27, 2013, generally to be effective on January 1, 2014. The impacted regulations include:

- Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (CMS-1526-F).
- CY 2014 Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (CMS-1601-FC).
- CY 2014 Home Health Prospective Payment System Final Rule (CMS-1450-F).
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014 Final Rule with Comment Period (CMS-1600-FC).

Source: LEARNRESOURCE-L E-mail Update, National Institutes of Health, U.S. Department of Health and Human Services dated October 23, 2013.

Revisions and Deletions to the Internet Only Manual Related to Extended Repayment Schedules

MLN Matters® Number: MM8347
Related Change Request (CR) #: CR 8347
Related CR Release Date: August 2, 2013
Related CR Transmittal #: R224FM
Effective Date: September 3, 2013
Implementation Date: September 3, 2013

Provider Types Affected

This MLN Matters® article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Post Hospital Home Health (HHH), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs),) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8347 is a policy change that streamlines the Extended Repayment Schedules (ERS) process by updating the policy language and standard practices. See the Key Points section of this article for specifics.

Background

Overpayments are Medicare payments to a provider that are in excess of amounts due and payable under the statute and regulations. When an overpayment is determined, a demand letter is sent requesting repayment. A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" for the provider, the provider may request an ERS at any time the overpayment is outstanding. Medicare Contractors and/or Centers for Medicare & Medicaid Services (CMS) staff will review the request to determine if extending a repayment schedule is justified.

Key Points

The following points are based on the revised manual, "Medicare Financial Management," Chapter 4 – Debt Collection:

- Medicare contractors are charged with establishing an ERS formerly called an Extended Repayment Plan (ERP). Contractors must process ERS requests within 30 days of receipt and make certain providers complete all instructions. Contractors are required to post information and instructions on their websites and supply paper copies if requested.
- Your Medicare contractor will approve/disapprove an ERS request from 6 months up to 36 months and the CMS for an ERS up to 60 months—again within 30 days of receipt.
- Your Medicare contractor will not refund monies recouped during the review process. The recouped amounts will be applied to the overpayment.
- Contractors will notify a provider of approval or no approval within 5 days of decision.
- Contractors will recoup ERS payments from a provider's future Medicare payment, unless the contractor determines there is a valid reason to send in a check.
- Chapter 4, Section 100.6.4 details the ERS process that occurs if a request is received by the Recovery Audit Contractor (RAC) from a provider. The point of contact information for the ERS at the RAC location will be provided in a separate instruction.

Additional Information

The official instruction, CR8347 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R224FM.pdf on the CMS website.

You may review CR7688 for an explanation of the policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7688.pdf on the CMS website.

Non-Alert RARCs – Further Instruction – Revised

MLN Matters® Number: MM8391 Revised
Related Change Request (CR) #: CR 8391
Related CR Release Date: August 16, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R1285OTN
Implementation Date: October 7, 2013, except January 6, 2014 for DME MACs

This article was revised on August 22, 2013, to revise the title. All other information is the same.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 7910 was implemented by Medicare in April, 2013. CR7910 included a Business Requirement (BR 7910.2) instructing the Medicare Shared Systems (SSs) and contractors to stop sending Non-Alert Remittance Advice Remark Codes (RARCs) without associated Group Codes and/or Claim Adjustment Reason Codes (CARCs). It has been reported that this resulted in provider concern and increased provider inquiries. The Centers for Medicare & Medicaid Services (CMS) is working on developing a long term resolution but has decided to continue to send Non-Alert RARCs without any Group Code and/or CARC for now.

Additional Information

The official instruction, CR8391 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1285OTN.pdf on the CMS website.

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

MLN Matters® Number: MM8365
Related Change Request (CR) #: CR 8365
Related CR Release Date: August 16, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1281OTN
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8365, from which this article is taken, instructs Medicare contractors and Shared System Maintainers (SSM) to use (effective January 1, 2014) the May 24, 2013 update to the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios, version 3.0.2.

Background

On August 7, 2012, the Department of Health and Human Services (HHS) announced adoption of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set. (Refer to http://www.hhs.gov/news/press/2012pres/08/20120807a.html on the Centers for Medicare & Medicaid Services (CMS) website). In CR8182, released on May 9, 2013, CMS instructed Medicare contractors to implement this rule set by January 6, 2014. (You can find the associated MLN Matters® Article, MM8182 "Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8182.pdf on the CMS website.

The EFT & ERA Operating Rule Set includes the following rules:

1. Phase III CORE 380 EFT Enrollment Data Rule.
2. Phase III CORE 382 ERA Enrollment Data Rule.
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule:
    - CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.
4. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule.
5. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

The Health Insurance Portability and Accountability Act (HIPAA) initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim or service has been adjudicated, and now the ERA/EFT Operating Rules under the Affordable Care Act are mandating consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios and specify the maximum set of the standard code combinations that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations of existing codes based on business policy change and/or Federal/State Mandate.

CR8365, from which this article is taken, focuses on rule 3 , and instructs Medicare contractors and Shared System Maintainers (SSM) to use (to be effective January 1, 2014, and to be implemented by January 6, 2014) the May 24, 2013 updated CORE Combination Lists in the document: "CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios," version 3.0.2 (which you will find as an attachment to CR8365).

The following are the CORE-defined Claim Adjustment/Denial Business Scenarios and Descriptions:

Scenario #1: Additional Information Required - Missing/Invalid/Incomplete Documentation

This scenario refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3: Billed Service Not Covered by Health Plan

Refers to situations where the billed service is not covered by the health plan.

Scenario #4: Benefit for Billed Service Not Separately Payable

Refers to situations where the billed service or benefit is not separately payable by the health plan.

Medicare is implementing the code combinations per the ERA/EFT Operating Rules in 2 releases (July and October 2013) that relate to these 4 scenarios (per CR 8182), and is adding the updates to CORE CODE Combinations (per CR8365), effective January 1, 2014. Finally, the Medicare Remit Easy Print (MREP) and PC Print, will be updated if needed, by January 6, 2014.

Additional Information

The official instruction, CR8365 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1281OTN.pdf on the CMS website.

MREP Annual Enhancement

MLN Matters® Number: MM8467
Related Change Request (CR) #: CR 8467
Related CR Release Date: September 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2795CP
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8467 which informs Medicare contractors about the following annual changes to the Medicare Remit Easy Print (MREP) software. Those changes are:

- Revise the MREP remittance advice layout to remove the blank line after each set of Claim Line details.
- Revise the MREP remittance advice layout by adding the Claim Adjustment Reason Code (CARC) Adjustment Amount (CARC-AMT) to the fields subtotaled for each claim.

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

Background

The Centers for Medicare & Medicaid Services (CMS) developed the MREP software to help providers to transition from paper to electronic format of the remittance advice. The Electronic Remittance Advice (ERA) must be the standard format adopted under the Health Insurance Accountability and Portability Act (HIPAA). Currently the HIPAA adopted standard is the ASC X12 Transaction 835 version 005010A1. MREP users can view and print the ERA in humanly readable format and can send a hard copy remittance advice with their claims to payers after Medicare. Additionally, MREP users can run and download a number of special reports that have been added in response to enhancement requests from users. This software is available for free and has been updated on a yearly basis since its introduction in October 2005. CR8467 is instructing VIPs - the software developer - to update MREP based on requests received from users through the MACs and/or the CMS website.

Additional Information

The official instruction, CR 8467 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2795CP.pdf on the CMS website.

New CARC to Identify a Reduction in Payment Due to Sequestration – Revised

MLN Matters® Number: MM8378 Revised
Related Change Request (CR) #: CR 8378
Related CR Release Date: July 25, 2013
Effective Date: June 3, 2013
Related CR Transmittal #: R2739CP
Implementation Date: January 6, 2014

Note: This article was revised on September 5, 2013, to revise the title to be consistent with the Change Request. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

This article is based on CR 8378 which informs Medicare contractors about a new Claim Adjustment Reason Code (CARC) reported when payments are reduced due to Sequestration. Make sure that your billing staffs are aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013, canceling budgetary resources across the Federal Government. As a result, Medicare Fee-For-Service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. The Centers for Medicare & Medicaid services (CMS) previously assigned CARC 223 (Adjustment code for mandated Federal, State or Local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253 - Sequestration - Reduction in Federal Spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR8378.

Additional Information

The official instruction, CR 8378 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf on the CMS website.

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM8422
Related Change Request (CR) #: CR 8422
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2776CP
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and Medicare Administrative Contractors (A/B MAC) for services to Medicare beneficiaries.

What You Need To Know

CR 8422, from which this article is taken, updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists, effective October 1, 2013; and also instructs the Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. You should make sure that your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions, adopted under HIPAA, using valid standard codes. Accordingly, Medicare policy states that two standard code sets (Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) must be used for:

- Transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, (along with Group Code) to report payment adjustments; and Informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COB)).

Staff at the Centers for Medicare & Medicaid Services (CMS) usually request the CARC and RARC changes that impact Medicare, in conjunction with a policy change. If an entity other than CMS initiates a modification for a code that Medicare currently uses, contractors must either use the modified code (or another code), if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

CARC and RARC code sets are regularly updated three times a year. CR 8422 lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 262686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets.

Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR 8281

These are the changes in the CARC database since the last code update CR8281. The full CARC list may be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the Internet.

New Codes – CARC:

Code	Narrative	Effective Date
253	Sequestration - reduction in federal spending.	06/02/2013
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA).	06/02/2013
256	Service not payable per managed care contract.	06/02/2013
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA).	06/02/2013
W6	Referral not authorized by attending physician per regulatory requirement.	06/02/2013
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	06/02/2013
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	06/02/2013
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	06/02/2013

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	06/02/2013
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO).	06/02/2013
45	Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement (Use only with Group Codes PR or CO depending upon liability.)	07/01/2013
136	Failure to follow prior payer's coverage rules (Use only with Group Code OA).	07/01/2013
163	Attachment/other documentation referenced on the claim was not received.	06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	06/02/2013
173	Service/equipment was not prescribed by a physician.	07/01/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement (Use only with Group Code PR).	07/01/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected (Use only with Group code OA).	07/01/2013
221	Claim is under investigation. **Note:** If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used by Property & Casualty only.	07/01/2013
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	07/01/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. **Note:** This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer (Use only with Group Code PR).	07/01/2013

Code	Modified Narrative	Effective Date
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	07/01/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (Use only with Group Code PR).	07/01/2013
242	Services not provided by network/primary care providers. **Note:** This code replaces deactivated code 38.	06/02/2013
243	Services not authorized by network/primary care providers. **Note:** This code replaces deactivated code 38.	06/02/2013
250	The attachment/other documentation content received is inconsistent with the expected content.	06/02/2013
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	06/02/2013
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/02/2013
W1	Workers' compensation jurisdictional fee schedule adjustment. **Note:** If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply.	06/02/2013
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. **Note:** If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	06/02/2013
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note:** If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013

Code	Modified Narrative	Effective Date
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note:** If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. **Note:** If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013

Deactivated Codes (Also included in CR 8281) – CARC

Code	Current Narrative	Effective Date
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	11/01/2013

Changes in RARC List Since CR 8281

These are the changes in the RARC database since the last code update CR8281. The full RARC list may be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the internet.

New Codes– RARC:

Code	Current Narrative	Effective Date
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	07/15/2013
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	07/15/2013
N576	Services not related to the specific incident/claim/accident/loss being reported.	07/15/2013
N577	Personal Injury Protection (PIP) Coverage.	07/15/2013
N578	Coverages do not apply to this loss.	07/15/2013
N579	Medical Payments Coverage (MPC).	07/15/2013
N580	Determination based on the provisions of the insurance policy.	07/15/2013
N581	Investigation of coverage eligibilty is pending.	07/15/2013
N582	Benefits suspended pending the patient's cooperation.	07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	07/15/2013

Code	Current Narrative	Effective Date
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	07/15/2013
N585	Benefits are no longer available based on a final injury settlement.	07/15/2013
N586	The injured party does not qualify for benefits.	07/15/2013
N587	Policy benefits have been exhausted.	07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.	07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	07/15/2013
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).	07/15/2013
N592	Adjusted because this is not the initial prescription oe exceeds the amount allowed for the initial prescription.	07/15/2013
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	07/15/2013
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	07/15/2013
N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	07/15/2013
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	07/15/2013
N597	Adjusted based on a medical provider's apportionment of care between related injuries and other unrelated medical conditions/injuries.	07/15/2013
N598	Health care policy coverage is primary.	07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.	07/15/2013
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.	07/15/2013
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.	07/15/2013
N602	Adjusted based on the Redbook maximum allowance.	07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.	07/15/2013

Code	Current Narrative	Effective Date
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.	07/15/2013
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.	07/15/2013
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.	07/15/2013
N607	Service provided for non-compensable condition(s).	07/15/2013
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.	07/15/2013
N609	80% of the providers billed amount is being recommended for payment according to Act 6.	07/15/2013
N610	**Alert:** Payment based on an appropriate level of care.	07/15/2013
N611	Claim in litigation. Contact insurer for more information.	07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	07/15/2013
N613	**Alert:** Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.	07/15/2013
N614	**Alert:** Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).	07/15/2013
N615	**Alert:** This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.	07/15/2013
N616	**Alert:** This enrollee is in the first month of the advance premium tax credit grace period.	07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.	07/15/2013
N618	**Alert**: This claim will automatically be reprocessed if the enrollee pays their premiums.	07/15/2013
N619	Coverage terminated for non-payment of premium.	07/15/2013
N620	**Alert:** This procedure code is for quality reporting/informational purposes only.	07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	07/15/2013
N622	Not covered based on the date of injury/accident.	07/15/2013

Code	Current Narrative	Effective Date
N623	Not covered when deemed unscientific/unproven/outmoded/ experimental/excessive/inappropriate.	07/15/2013
N624	The associated Workers' Compensation claim has been withdrawn.	07/15/2013
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.	07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.	07/15/2013
N627	Service not payable per managed care contract.	07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	07/15/2013
N629	Reviews/documentation/notes/summaries/reports/charts not requested.	07/15/2013
N630	Referral not authorized by attending physician.	07/15/2013
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.	07/15/2013
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	07/15/2013
N633	Additional anesthesia time units are not allowed.	07/15/2013
N634	The allowance is calculated based on anesthesia time units.	07/15/2013
N635	The Allowance is calculated based on the anesthesia base units plus time.	07/15/2013
N636	Adjusted because this is reimbursable only once per injury.	07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.	07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.	07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.	07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.	07/15/2013
N641	Reimbursement has been based on the number of body areas rated.	07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.	07/15/2013
N643	The services billed are considered Covered or Non-Covered (NC) in the applicable state fee schedule.	07/15/2013
N644	Reimbursement has been made according to the bilateral procedure rule.	07/15/2013
N645	Mark-up allowance.	07/15/2013
N646	Reimbursement has been adjusted based on the guidelines for an assistant.	07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).	07/15/2013
N648	Adjusted based on Stop Loss.	07/15/2013
N649	Payment based on invoice.	07/15/2013
N650	This policy was not in effect for this date of loss. No coverage is available.	07/15/2013
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	07/15/2013
N652	The date of service is before the date of loss.	07/15/2013

Code	Current Narrative	Effective Date
N653	The date of injury does not match the reported date of loss.	07/15/2013
N654	Adjusted based on achievement of maximum medical improvement (MMI).	07/15/2013
N655	Payment based on provider's geographic region.	07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.	07/15/2013
N657	This should be billed with the appropriate code for these services.	07/15/2013
N658	The billed service(s) are not considered medical expenses.	07/15/2013
N659	This item is exempt from sales tax.	07/15/2013
N660	Sales tax has been included in the reimbursement.	07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.	07/15/2013
N662	**Alert:** Consideration of payment will be made upon receipt of a final bill.	07/15/2013
N663	Adjusted based on an agreed amount.	07/15/2013
N664	Adjusted based on a legal settlement.	07/15/2013
N665	Services by an unlicensed provider are not reimbursable.	07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.	07/15/2013
N667	Missing prescription	07/15/2013
N668	Incomplete/invalid prescription	07/15/2013
N669	Adjusted based on the Medicare fee schedule.	07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.	07/15/2013
N672	**Alert:** Amount applied to Health Insurance Offset.	07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.	07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.	07/15/2013
N675	Additional information is required from the injured party.	07/15/2013
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	07/15/2013

Modified Codes – RARC

Code	Current Narrative	Effective Date
N1	**Alert:** You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.	07/15/2013
N7	**Alert:** Processing of this claim/service has included consideration under Major Medical provisions.	07/15/2013
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	07/15/2013
N441	This missed/cancelled appointment is not covered.	07/15/2013

Deactivated Codes – RARC NONE

Additional Information

The official instruction, CR 8422 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2776CP.pdf on the CMS website.

Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice – Second Revision

MLN Matters® Number: MM8182 Revised
Related Change Request (CR) #: CR 8182
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R12910TN
Implementation Date: October 7, 2013, except January 6, 2014 for claims processed by DME MACs

Note: This article was revised on September 4, 2013, to reflect a revised CR8182 issued on August 30. In the article, the CR release date, transmittal number, the implementation date, and the Internet address for accessing the CR were revised. All other information remains the same.

Provider Types Affected

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

What You Need To Know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at http://aspe.hhs.gov/admnsimp/pl104191.htm#1173 on the internet.)

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 and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to Electronic Data Interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at http://www.ncvhs.hhs.gov/ on the internet.)

Note: The same rules will also apply to Standard Paper Remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA Operating Rule Set includes the following rules:
Please note that CR 8182 focuses only on rule numbers 3 and 4)

- Phase III CORE 380 EFT Enrollment Data Rule.
- Phase III CORE 382 ERA Enrollment Data Rule.
- Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.
- CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

- Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule.
- Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT Operating Rules under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT Operating Rules mandate consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up.
- Faulty electronic secondary billing.
- Inappropriate write-offs of billable charges.
- Incorrect billing of patients for co-pays and deductibles.
- Posting delay.

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: **Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule)**, that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional Information Required - Missing/Invalid/Incomplete Documentation

This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed Service Not Covered by Health Plan

This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for Billed Service Not Separately Payable

This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

Additional Information

The official instruction, CR8182, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1291OTN.pdf on the CMS website. You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) as an attachment to that CR.

Results of Widespread Prepayment Probe Review of Respiratory Assist Device (HCPCS E0470)

Review Results

Jurisdiction D, DME MAC, Medical Review Department completed a widespread prepayment probe review of HCPCS code E0470. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The E0470 review involved 124 claims, of which 98 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 75%.

Primary Documentation Errors that Resulted in Denial of Claims

Criterion D not met. (No/invalid documentation to support a new initial face to face for a beneficiary who switched to an E0470 after greater than 3 months use of E0601)

An E0470 device is covered for those beneficiaries with OSA who meet criteria A-C above, in addition to criterion D:

1. An E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting.
2. **Criterion A not met. (Face-to-face clinical evaluation)**

   The patient must have a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea. (Criteria A of LCD L171)
3. **Criterion B not met. (Sleep test)**

   The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

   - The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events.
   - The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
     - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia.
     - Hypertension, ischemic heart disease, or history of stroke.
4. **Criterion C not met. (Education)**

The beneficiary and/or their caregiver have received instruction from the supplier of the device in the proper use and care of the equipment.

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS code E0470 in LCD L171.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the CPAP Local Coverage Determination (LCD) L171 and Policy Article A19827.

Suppliers can also review specific policy resources for Respiratory Assist Devices on the Noridian located website at Positive Airway Pressure (PAP) Devices Consolidated Resources | Durable Medical Equipment | Noridianmedicare.com There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

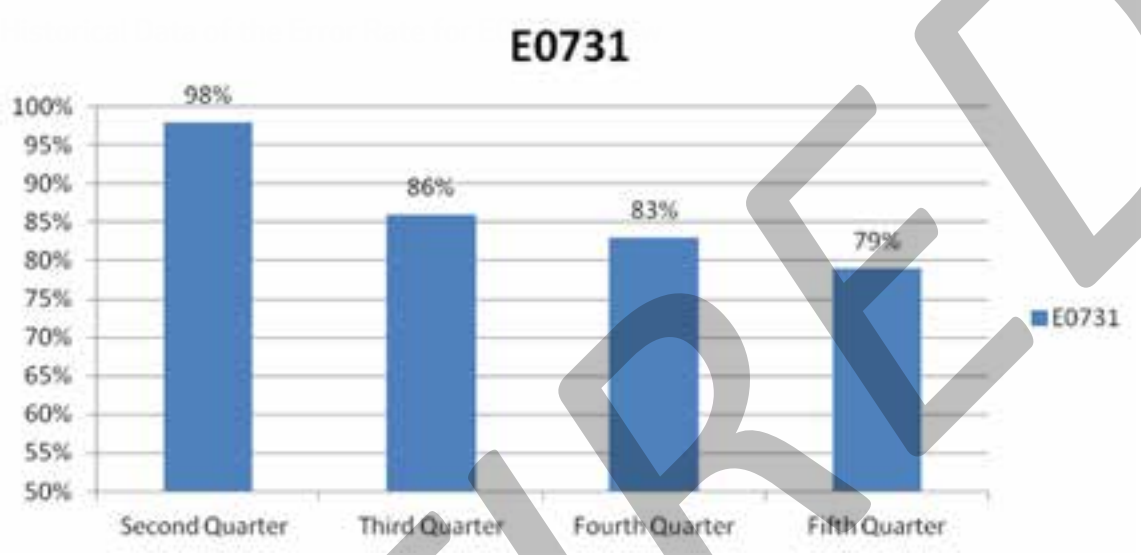
Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Fifth Quarter Results of Widespread Prepayment Review of Claims for Conductive Garment for Delivery of TENS or NMES (HCPCS E0731)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code E0731. The fifth quarter edit effectiveness results from April 17, 2013 through July 16, 2013 are as follows:

- The E0731 review involved 83 claims of which 61 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.



Primary Documentation Errors that Resulted in Denial of Claims

There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.

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

The documentation does not support coverage of the garment purchase.

Per LCD L11495, a conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but may be covered if all of the following conditions are met:

1. It has been prescribed by a physician for use in delivering covered TENS treatment.
2. One of the medical indications outlined below is met:
   - The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
   - The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
   - The patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires.
   - The patient requires electrical stimulation beneath a cast to treat chronic intractable pain.

There is no proof of delivery (POD) submitted.

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

The proof of delivery (POD) provided was invalid.

Suppliers are required to maintain POD documentation in their files. There are 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 item must be the date of service on the claim.

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

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

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

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

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

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

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

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

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

Going Forward

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

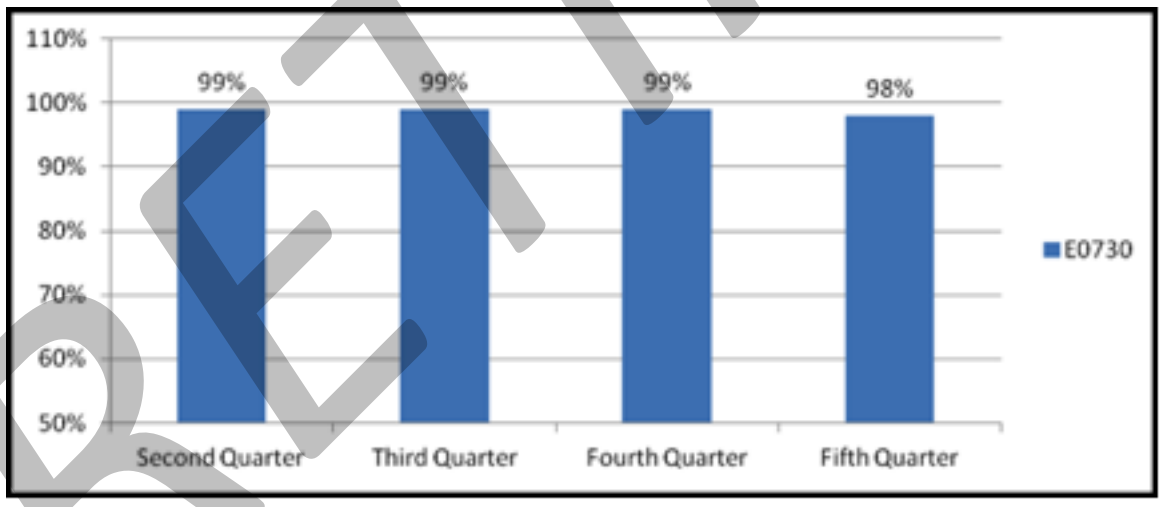
Fifth Quarter Results of Widespread Prepayment Review of Claims for Transcutaneous Electrical Nerve Stimulators (TENS) Device, Four or More Leads (HCPCS E0730)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code E0730. The fifth quarter edit effectiveness results from April 17, 2013 through July 16, 2013 are as follows:

- The E0730 review involved 124 claims, of which 118 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

Historical Data of the Error Rate for E0730 Review



Primary Documentation Errors that Resulted in Denial of Claims

There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.

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

There were no office notes or no medical records 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.

The documentation provided does not support why the 2 leads are insufficient to meet the patient's needs.

Per LCD L11495, a TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patient's needs.

The documentation provided does not support usage and frequency.

Per LCD L11495, For chronic pain covered under criterion II, there must be information in the medical record describing:

- The location of the pain.
- The severity of the pain.
- The duration of time the beneficiary has had the pain.
- The presumed etiology of the pain.
- Prior treatment and results of that treatment.
- Reevaluation of the beneficiary at the end of the trial period, must indicate.
    - How often the beneficiary used the TENS unit.
    - The typical duration of use each time.
    - The results (effectiveness of therapy).

Quarterly Results of Widespread Prepayment Review of Claims for Conductive Garment for Delivery of TENS or NMES (HCPCS E0731)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code E0731. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

- The E0731 review involved 89 claims, of which 67 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 73%.

Primary Documentation Errors that Resulted in Denial of Claims

There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.

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

The documentation provided does not support coverage of the garment purchase.

Per LCD L11495, a conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but may be covered if all of the following conditions are met:

1. It has been prescribed by a physician for use in delivering covered TENS treatment.

2. One of the medical indications outlined below is met:

- The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.
- The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.
- The patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires.
- The patient requires electrical stimulation beneath a cast to treat chronic intractable pain.

There is no proof of delivery (POD) submitted.

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

There are no medical records or office notes 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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for Transcutaneous Electrical Nerve Stimulators (TENS) on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/docs/checklists/transcutaneous_electrical_nerve_stimulators_tens.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

Quarterly Results of Widespread Prepayment Review of Claims for TENS Device, Four or More Leads (HCPCS E0730)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0730. The quarterly edit effectiveness results from July 2013 through October 2013 are as follows:

- The E0730 review involved 130 claims, of which 123 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 96%.

Primary Documentation Errors that Resulted in Denial of Claims.

The documentation provided does not support usage and frequency.

Per LCD L11495, For chronic pain covered under criterion II, there must be information in the medical record describing:

- The location of the pain.
- The severity of the pain.
- The duration of time the beneficiary has had the pain.
- The presumed etiology of the pain.
- Prior treatment and results of that treatment.
- Reevaluation of the beneficiary at the end of the trial period, must indicate.
  - How often the beneficiary used the Transcutaneous Electrical Nerve Stimulator) (TENS) unit.
  - The typical duration of use each time.
  - The results (effectiveness of therapy).

The documentation provided does not support why the 2 leads are insufficient to meet the patient's needs.

Per LCD L11495, a TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patient's needs.

There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.

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

The documentation provided does not support other treatments 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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the TENS Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for TENS on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/docs/checklists/transcutaneous_electrical_nerve_stimulators_tens.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

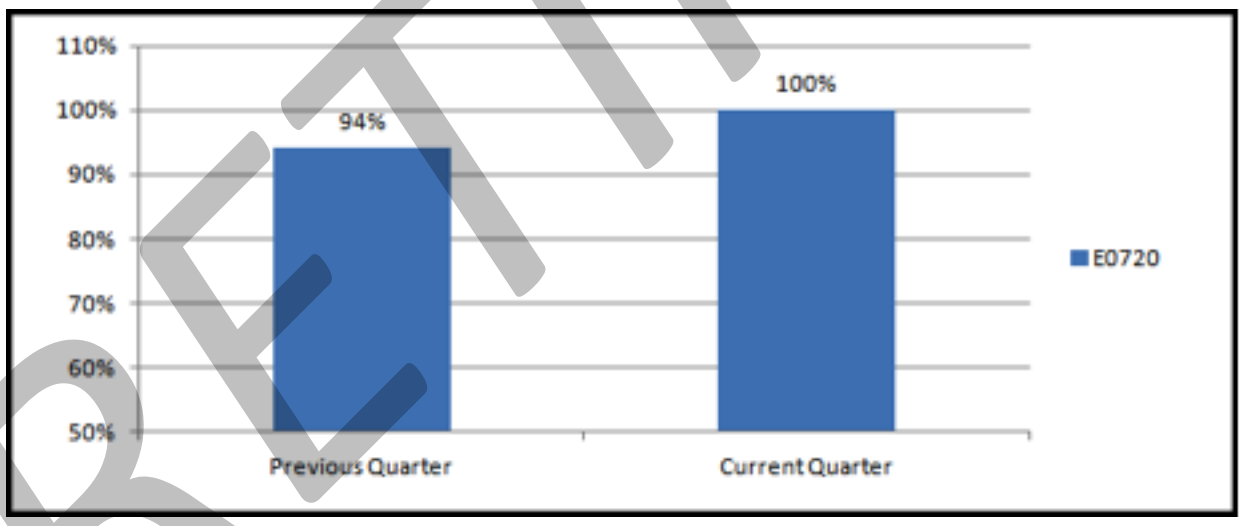
Quarterly Results of Widespread Prepayment Review of Claims for Transcutaneous Electrical Nerve Stimulators (TENS) 2-LEAD (HCPCS E0720)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code E0720. The quarterly edit effectiveness results from May 17, 2013 through August 16, 2013 are as follows:

- The E0720 review involved 7 claims, of which 7 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

Historical Data of the Error Rate for E0720 Review



Primary Documentation Errors that Resulted in Denial of Claims

The documentation provided does not support usage and frequency.

Per LCD L11495, For chronic pain covered under criterion II, there must be information in the medical record describing:

- The location of the pain.
- The severity of the pain.
- The duration of time the beneficiary has had the pain.
- The presumed etiology of the pain.

- Prior treatment and results of that treatment.
- Reevaluation of the beneficiary at the end of the trial period, must indicate.
  - How often the beneficiary used the TENS unit.
  - The typical duration of use each time.
  - the results (effectiveness of therapy).

There were no Detailed Written Orders provided.

Per PIM 5.2.1, All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

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.

Per PIM 5.2.4, A detailed written order 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 DWO before dispensing the item.

There were no office notes or no medical records 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.

The documentation provided does not support other appropriate treatment modalities had been tried and failed.

Per LCD L11495, other appropriate treatment modalities must have been tried and failed, and the medical record must document prior treatment and results of that treatment.

Going Forward

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

Quarterly Results of Widespread Prepayment Review of Claims for Therapeutic Shoes for Persons with Diabetes (HCPCS A5500)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code A5500. The quarterly edit effectiveness results from June, 2013 through September, 2013 are as follows:

- The A5500 review involved 3,555 claims, of which 2,967 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 83%.

Primary Documentation Errors that Resulted in Denial of Claims

Criterion 2 not met per Policy Article (PA) A37076.

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

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

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

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

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

No documentation was received.

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

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

Criterion 3 not met per PA A37076.

There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts.

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

Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

Criterion 4 not met - documentation of in-person visit prior to selection of item incomplete per Local Coverage Determination (LCD) L157 and PA A37076.

There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

- An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
- For all shoes, taking measurements of the patient's feet.

For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

Going Forward

Based on high error rate, Noridian will continue with the Prepayment Widespread Review.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076.

Suppliers can also review specific policy resources for Therapeutic Shoes for Persons with Diabetes on the Noridian website located at https://www.noridianmedicare.com/dme/coverage/resources/therapeutic_shoes_for_persons_with_diabetes.html. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

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

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

Quarterly Results of Widespread Prepayment Review of Claims for Male Vacuum Erection System (HCPCS L7900)

Current Review Results

- The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code L7900. The quarterly edit effectiveness results from May 2013 through August 2013 are as follows:
- The L7900 review involved 282 claims, of which 202 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

Documentation submitted did not support medical necessity of the item ordered.

The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by Medicare, the beneficiary's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. There must be information in the beneficiary's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

No documentation was received.

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

An invalid Proof of Delivery (POD) was submitted.

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

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

- When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.
- No office notes or medical records were submitted.

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

Going Forward

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

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES