DME Happenings

Jurisdiction D
Issue No. 39
June 2013

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

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

noridian Healthcare Solutions

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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PRESSURE REDUCING SUPPORT SURFACES

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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

CONTACT US

Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian PO Box 6728 Fargo ND 58108-6728	**DME Recovery Auditor Overpayments** Noridian PO Box 6759 Fargo ND 58108-6759

Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
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) [PDF] system (1-877-320-0390) and Endeavor, the Noridian DME Jurisdiction D supplier portal, will each continue to be available on these dates to assist suppliers with their claim status, eligibility, remittance advice, same and/or similar inquiries

Event	Date	Closure Timeframe
Off-the-Phone Training	May 24	9:30 a.m. – 12 p.m. CT
Memorial Day	May 27	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	June 14	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 21	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	June 28	9:30 a.m. – 12 p.m. CT
Independence Day	July 4	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	July 12	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 19	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	July 26	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 9	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 16	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	August 23	9:30 a.m. – 12 p.m. CT

Event	Date	Closure Timeframe
Labor Day	September 2	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	September 13	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 20	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	September 27	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 11	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 18	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 25	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	October 25	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	November 15	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	November 22	9:30 a.m. – 12 p.m. CT
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 one day each month between 8 a.m. and 10 a.m. CT to receive training. The holiday and training closures are provided below.

Event	Date	Closure Timeframe
Memorial Day	May 27	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	June 7	8 – 10 a.m. CT
Independence Day	July 4	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	August 2	8 – 10 a.m. CT
Labor Day	September 2	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	September 6	8 – 10 a.m. CT
Off-the-Phone Training	October 4	8 – 10 a.m. CT
Off-the-Phone Training	November 1	8 – 10 a.m. CT
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
Christmas	December 24	12 – 4 p.m. CT
Christmas	December 25	Entire Day Closed 8 a.m. – 4:30 p.m. CT

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card

- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Clarify the Definition of Customized DME Items

MLN Matters® Number: MM8194
Related Change Request (CR) #: CR 8194
Related CR Release Date: April 19, 2013
Related CR Transmittal #: R460PI and R2687CP
Effective Date: January 1, 1992
Implementation Date: July 19, 2013

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare contractors (Regional Home Health Intermediary (RHHI) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for customized DME items for Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8194 and clarifies instructions regarding the definition of certain customized items.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying the definition of certain customized items in the revised Section 30.3 of Chapter 20 of the "Medicare Claims Processing Manual." According to CMS, customized items are rarely necessary and are rarely furnished.

In accordance with 42 CFR Section 414.224, in order to be considered a customized item, a covered item (including a wheelchair) must be uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of a physician and be so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

For example, a wheelchair that is custom fabricated or substantially modified so that it can meet the needs of wheelchair-confined, conjoined twins facing each other is unique and cannot be grouped with any other wheelchair used for the same purpose. It is a one-of-a-kind item fabricated to meet specific needs. Items that are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items) or have been assembled by a supplier or ordered from a manufacturer who makes available customized features, modification, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician do not meet the definition of customized items. These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes.

Key Points

The following Key Points are outlined in Chapter 20, Section 30.3 of the Medicare Claims Processing Manual:

- The item must be uniquely constructed using raw materials or there must be a necessary, substantial modification to the base equipment (e.g., wheelchair frame) for the item to be considered a customized item;
- The use of customized options or accessories or custom fitting of certain parts does not result in a wheelchair or other equipment being considered as customized; and

- The definition of customized DME set forth in regulations at 42 CFR Section 414.224 is based on the longstanding definition of customized DME used in making decisions regarding when to make individual payment determinations outside the normal process for calculating customary and prevailing charges under the reasonable charge payment methodology used for DME prior to 1989. You may review that definition by reading Section 30.3 in Chapter 20 of the "Medicare Claims Processing Manual" attached to CR8194 at the web address listed in the Additional Information section of this article.
- An item must meet both parts of the definition in order to be considered a customized item. Items that are uniquely constructed or substantially modified for a specific beneficiary must, more importantly, also be so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. If an item can be priced, even if it is custom-made, made-to-measure, specially sized, etc., it is not a customized item. For example, a certain line of products may be furnished based on individual measurements or conditions of the patient, but the product line and customization process is known and the items can be grouped together for pricing purposes.

Additional Information

The official instruction, CR8194, was issued to your RHHI or DME MAC regarding this change via two transmittals. The first updates the "Medicare Claims Processing Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2687CP.pdf on the CMS website. The second updates the "Medicare Program Integrity Manual" and that transmittal is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R460PI.pdf on the CMS website.

HETS to Replace CWF Medicare Beneficiary Health Insurance Eligibility Queries

MLN Matters® Number: SE1249 Revised

Note: This article was revised on April 23, 2013, to update certain language to reflect the current status of this change. Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3.

Provider Types Affected

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

Provider Action Needed

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

What You Need to Know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the Multi-Carrier System (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. A change request will be issued later this year to terminate these queries effective April 2014. This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare Contractor's Interactive Voice Response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's Health Care Eligibility

Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key Points

General Information

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

HETS

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

Frequently Asked Questions

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

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

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

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

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

By April 2014, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF. These changes will be in place before the April 2014 termination date for the FISS DDE CWF query access.

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

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

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

Additional Information

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

Mandatory Payment Reductions in the Medicare Fee-for-Service (FFS) Program – "Sequestration"

To All Health Care Professionals, Providers, and Suppliers

The Budget Control Act of 2011 requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. The Administration continues to urge Congress to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.

This listserv message is directed at the Medicare FFS program (i.e., Part A and Part B). In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment shall be applied to all claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.**

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

Questions about reimbursement should be directed to your Medicare claims administration contractor. As indicated above, we are hopeful that Congress will take action to eliminate the mandatory payment reductions.

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."

Noridian Changes Name to Noridian Healthcare Solutions (Noridian)

Effective today, May 13, Noridian Administrative Services (Noridian) has officially changed its name to Noridian Healthcare Solutions (Noridian) to better reflect the scope of capabilities that have grown from our core business.

The name change accompanies a move to diversify

Since 1966, we have been administering services for state and federal health care programs, and for North Dakota's dominant private insurer. While we continue to serve them, the name change is part of a much larger initiative to position ourselves to serve clients long into the future with expanded services including:

- Broader and more robust administrative services;
- Care and delivery management solutions to increase patient care quality while decreasing cost;
- Program integrity offerings including medical review to reduce fraud and abuse;
- Health Insurance Exchange (HIX) solutions including development, support and ongoing administration for state and federal health insurance marketplaces; and,
- Utilization and analysis of health care data to drive business decision-making.

Today, approximately 1,100 Noridian employees serve 13.1 million beneficiaries and 290,000 health care providers in all 50 states. As those numbers grow, so too will the opportunities to provide current and future clients with comprehensive, cost-effective services.

Quarterly Provider Updates

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

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

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

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.

APPEALS

Calendar Year 2013 Update to Amount in Controversy Requirements for ALJ and Federal District Court Appeals

The Medicare Prescription Drug, Improvement, and Modernization Act requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. The amount in controversy increases by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2012, is $130. This amount increases to $140 for ALJ hearing requests filed on or after January 1, 2013. The amount that must remain in controversy for Federal District Court review requests filed on or before December 31, 2012 is $1,350. This amount increases to $1,400 for appeals to Federal District Court filed on or after January 1, 2013.

Denied Claims Requiring CMN/DIF Must be Resubmitted, Rather than Reopened

Effective April 1, 2013, claims that are denied for no Certificate of Medical Necessity (CMN)/ DME Information Form (DIF) will no longer be reopened via a telephone reopening and must be resubmitted with the applicable CMN/DIF. Suppliers can expect the following claim adjustment reason code (CARC) and remittance advice remark code (RARC) combinations on their remittance advice:

CARC 173 and RARC M60 for no CMN

CARC 176 and RARC N170 for no recertification or revised CMN

Policies requiring a CMN/DIF include Oxygen, Pneumatic Compression Devices, Osteogenesis Stimulators, Transcutaneous Electrical Nerve Stimulators (TENS), External Infusion Pumps, Enteral, Parenteral Nutrition and Seat Lift Mechanisms.

Note: This change does not affect Appeal Rights.

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, specifically • 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.

April Quarterly Update for 2013 DMEPOS Fee Schedule

MLN Matters® Number: MM8204
Related Change Request (CR) #: CR 8204
Related CR Release Date: February 22, 2013
Related CR Transmittal #: R2661CP
Effective Date: January 1, 2013 for fee schedule amounts for codes in effect on January 1, 2013; April 1, 2013 for all other changes
Implementation Date: April 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (MACs), carriers, and Durable Medical Equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider Action Needed

This article is based on Change Request (CR) 8204 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the "Medicare Claims Processing Manual," Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Key Points of CR8204

- The coverage indicators for Healthcare Common Procedure Coding System (HCPCS) codes L8680, L8682, L8683, L8684, L86885, L8686, L8687, and L8688 have changed from invalid for Medicare ("I") to special coverage instructions apply ("D"), effective January 1, 2013. This change to the coverage indicators for codes L8680 and L8682 through L8688 are noted in the 2013 HCPCS Correction file, posted at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html on the CMS website.
- The CY 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 are in the following table. The fee schedule amounts for these codes were updated for 2013 by applying the 2013 0.8 percent update factor to the 2012 fee schedule amounts.

	JURIS	CATG	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
AL	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
AR	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
AZ	L	PO	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
CA	L	PO	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
CO	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
CT	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
DC	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
DE	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
FL	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
GA	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
IA	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
ID	L	PO	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
IL	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
IN	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
KS	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
KY	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
LA	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
MA	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
MD	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
ME	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
MI	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
MN	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
MO	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
MS	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
MT	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
NC	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
ND	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
NE	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
NH	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
NJ	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
NM	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
NV	L	PO	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
NY	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
OH	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
OK	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
OR	L	PO	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
PA	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
RI	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
SC	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
SD	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
TN	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
TX	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
UT	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
VA	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
VT	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01

	JURIS	CATG	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
WA	L	PO	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
WI	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
WV	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
WY	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
AK	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HI	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PR	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
VI	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

- Take note that the 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 will not appear on the 2013 DMEPOS fee schedule files. A separate public use file containing only the 2013 fee schedule amounts for codes L8680, and L8682 through L8688 is available for download on the CMS DMEPOS fee schedule website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html on the CMS website.

Diabetic Testing Supplies

- In accordance with Section 636(b) of the American Taxpayer Relief Act of 2012 (ATRA), effective for claims with dates of service on or after April 1, 2013, the 2009 fee schedule covered item update for non-mail order diabetic supplies is revised from 5 percent to -9.5 percent. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as listed with the HCPCS codes below. As part of this update, the fee schedule amounts for these codes have been revised to reflect the change in the 2009 covered item update.
  - A4233 Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
  - A4234 Replacement Battery, Alkaline, J Cell, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
  - A4235 Replacement Battery, Lithium, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
  - A4236 Replacement Battery, Silver Oxide, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
  - A4253 Blood Glucose Test or Reagent Strips for Home Glucose Monitor, Per 50 Strips.
  - A4256 Normal, Low and High Calibration Solution / Chips.
  - A4258 Spring-powered Device for Lancet, Each.
  - A4259 Lancets, Per Box of 100.

Also, effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the ATRA, the fee schedule amounts for non-mail order diabetic supplies will be further adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Social Security Act. The national competitive bidding program for mail order diabetic supplies is scheduled to take effect July 1, 2013. The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 is:

- Mail Order Item (KL HCPCS modifier)-- Any item shipped or delivered to the beneficiary's home, regardless of the method of delivery.
- Non-Mail Order Item (KL modifier not applicable)-- Any item that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

A change request instruction and data file will be released for the July Quarterly Update to the 2013 DMEPOS Fee Schedule File to incorporate the new national payment amounts, and these amounts will be updated each time the amounts established in accordance with Section 1847 of the Act are updated. The single payment amount public use file for the national mail order competitive bidding program will be available at www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the internet.

Additional Information

The official instruction, CR8204 issued to your carrier, DME/MAC, or A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2661CP.pdf on the CMS website. Current and past DMEPOS Fee schedules can be viewed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html on the CMS website.

Claim Denials for Missing/Incomplete/Invalid Beneficiary Name or Number

When a supplier receives a remittance advice denial with the reason code CO-140, along with remark codes MA130 and MA61, contact to the beneficiary should be made to ensure you have their full name as shown on their Medicare card and the correct Health Insurance Claim Number (HICN). While the names and Medicare numbers may have been cross-referenced in the past and Medicare returned the name of the beneficiary that was associated with that HICN in its files, per CR 7260, the claims are now denied as unprocessable. In addition, the invalid name and Medicare number submitted by the supplier is returned on the remittance advice. Denied claims must be resubmitted with complete/correct information.

Below are some reasons suppliers may receive this denial (not all inclusive):

- Beneficiary's middle name was submitted because this is the name they go by (Suppliers must bill using the full name as shown on the patient's Medicare card and on file with the Social Security Administration)
- Beneficiary's name changed due to marriage
- New Medicare card issued because of death of a spouse and HICN changed
- Beneficiary provided their Social Security number, which is not always their Medicare number
- New Medicare card issued to beneficiary because of identity theft

Reason Code 140: Patient/Insured health identification number and name do not match.

Remark Code 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.

Remark Code MA61: Missing/incomplete/invalid social security number or health insurance claim number.

Suppliers are encouraged to verify the eligibility of the Medicare beneficiary using the Endeavor supplier portal or the Interactive Voice Response (IVR) based on the Medicare information provided by the beneficiary or taken from the Medicare card. To avoid errors that may lead to claim denials, we recommend the following:

- Use the full name as it appears on the Medicare card, avoiding the use of nicknames or middle names.
- Use surnames such as Father, Sister, Mother, Junior, Senior and related terms as part of the name if they appear on the Medicare card.
- Do NOT include hyphens or other symbols when verifying eligibility through Endeavor or the IVR or in claims submission. Leave a space when the hyphen or symbol exists. (Most software billing systems will not accept symbols in electronic submissions.)
- Include both portions of a hyphenated name in verifying eligibility or claim submission when they appear on the Medicare card in that format.
- Refer beneficiaries to the Social Security Administration (SSA) if the name and HICN are submitted exactly as it appears on the Medicare card and the claim is denied to request a new Medicare card. Ask the beneficiary to inform you of the name and HICN provided on the new Medicare card so the claim can be correctly submitted.

Additional resources available to assist suppliers on this topic include:

- HIC Prefixes and Suffixes
- CR 7260 [PDF]

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8265
Related Change Request (CR) #: CR 8265
Related CR Release Date: April 5, 2013
Related CR Transmittal #: R2681CP
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for all physicians, other 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

Change Request (CR) 8265, from which this article is taken, 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 January 2013 Committee meeting will be posted on or about March 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 to be reflected in the X12 277 transactions issued on and after the date of implementation of CR8265 (July 1, 2013).

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 CR8265 (July 1, 2013), your Medicare contractor must: 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, CR8265 issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2681CP.pdf on the CMS website.

Clarification of Detection of Duplicate Claims Section of CMS Internet Only Manual

MLN Matters® Number: MM8121
Related Change Request (CR) #: CR 8121
Related CR Release Date: March 29, 2013
Related CR Transmittal #: R2678CP
Effective Date: April 29, 2013
Implementation Date: April 29, 2013

Provider Types Affected

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

Provider Action Needed

The purpose of this Change Request (CR) is for clarification only and does not constitute any change in Medicare policy. The Centers for Medicare & Medicaid Services (CMS) is alerting providers to the update of the Medicare Internet-Only Manual (IOM), Chapter 1, Section 120: "Detection of Duplicate Claims."

Change Request (CR) 8121, from which this article is taken, alerts providers that the claims processing systems contain edits which identify duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare contractors to make a determination to pay or deny the claim or claim line.

Please be aware that Medicare contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors will check the diagnosis. If the diagnosis codes are duplicates, contractors will request an explanation before making payment. The official instruction for CR8121 spells out what your Medicare contractor looks for when analyzing the history of paid and pending claims, duplicate claims and the criteria for detecting suspect duplicate claims.

Background

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not.

For example, there are some Healthcare Common Procedure Coding System (HCPCS) modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The Level II modifiers "RT" and "LT," for example, indicate that a service was performed on the right and left side of the body, respectively.

However, not every HCPCS code has an appropriate modifier to indicate that a claim line is not a duplicate. In that case, the claims and claim lines are reviewed by Medicare Contactors' local software modules for a determination, or they suspend for contractor review.

Key Points of CR8121

Exact Duplicates

A. Submission of Institutional Claims

Claims or claim lines that have been determined an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Health Insurance Claim (HIC) number;
- Type of Bill;
- Provider Identification Number;
- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

Whenever any of the following claim situations occur, your Medicare contractor develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

B. Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

C. Claims Submitted by DMEPOS Suppliers

Claims or claim lines that have been determined an exact duplicate are denied. Such denials may not be appealed. An exact duplicate for DMEPOS Supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC Number;
- From Date of Service;
- Through Date of Service;
- Place of service;

- HCPCS;
- Type of Service;
- Billed Amount; and
- Supplier.

Suspect Duplicates

Suspect duplicates are claims or claim lines that contain closely aligned elements and require that the claim be reviewed.

D. Criteria for Detecting Suspect Duplicates on Institutional Claims

A "suspect duplicate" claim is a claim being processed which, when compared to Medicare's history or pending files, begins with these characteristics:

- Match on the beneficiary information;
- Match on provider identification; and
- Same date of service or overlapping dates of service.

E. Suspect Duplicate Claims Submitted by Physicians and other Suppliers (including DMEPOS Claims)

The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria. The denial of claim as a duplicate of another claim may be appealed when the denial is based on criteria other than those specified above for exact duplication.

Additional Information

You can find the official instruction, CR8121, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2678CP.pdf on the CMS website.

"Fragmented" Billing for Non-Participating Suppliers

Suppliers who enroll in the Medicare program have an option of being a participating or non-participating supplier. A supplier who enters into a participation agreement (CMS form 460) with Medicare agrees to accept assignment on all claims for Medicare services. Suppliers who do not enter into a participation agreement with Medicare (i.e., non-participating suppliers) may accept assignment on a claim-by-claim basis unless they are required by law to accept assignment.

The Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual (Internet-only Pub. 100-04), Chapter 1, Section 30.3.2 advises that non-participating suppliers may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" bills. Bills are considered "fragmented" when a supplier accepts assignment for some services, and payment from the enrollee for other services performed at the same place and on the same date of service.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) consider "fragmented" billing when a supplier bills the same Healthcare Common Procedure Coding System (HCPCS) code as some of the services assigned and some as non-assigned. In particular, there have been many questions regarding "fragmented billing" for External Breast Prostheses. For example, if a beneficiary receives two mastectomy bras (L8000) on the same day and at the same place, and the beneficiary assigns the claim to a supplier, the non-participating supplier may not bill one claim as non-assigned for an L8000 and another claim as assigned for an L8000. If so, this is considered fragmented billing. The non-participating supplier must choose to submit the two mastectomy bras (L8000) as either assigned or non-assigned claims.

However, if on the same day a beneficiary receives two mastectomy bras (L8000) and a silicone prosthetic (L8030) and the beneficiary assigns the claim to a non-participating supplier, the non-participating supplier may choose to either:

1. Submit the claims as assigned or non-assigned for all services, or
2. Submit one claim as assigned and the other as non-assigned (e.g., submit the prosthetic (L8030) as assigned on one claim and the mastectomy bras (L8000) as non-assigned on the other claim (or vice versa).

Suppliers may contact the National Supplier Clearinghouse for information on being a participating or non-participating supplier at 1-866-238-9652 from 9 a.m. until 5 p.m. ET to reach a customer service representative.

Healthcare Provider Taxonomy Codes Update, April 2013

MLN Matters® Number: MM8211
Related Change Request (CR) #: CR 8211
Related CR Release Date: February 15, 2013
Related CR Transmittal #: R2660CP
Effective Date: April 1, 2013
Implementation Date: July 1, 2013 (Contractors who have the capability may implement April 1, 2013 or after)

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8211 which instructs carriers and Part B MACS 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 for electronically transmitting certain health care transactions, among them health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Health care claims are among the health care transactions for which standards were adopted under HIPAA. Among the current versions of the standard implementation guides for health care claim transactions are the 5010 versions of the ASC X12 837 Institutional Technical Report 3 (TR3) for institutional claims and the ASC X12 837 professional TR3 for professional (and some supplier) claims. (There are other standards for other types of claims). Both the current ASC X12 837 institutional and professional TR3s require that the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code (HPTC) set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty.

The standards implementation guides state that this information is:

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

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

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

CR8211 implements the NUCC HPTC code set that is effective on April 1, 2013. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

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

Additional Information

The official instruction, CR8211, issued to your carriers and B MACs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2660CP.pdf on the CMS website.

July 2013 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Number: MM8247
Related Change Request (CR) #: CR 8247
Related CR Release Date: March 15, 2013
Related CR Transmittal #: R2676CP
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

Provider Action Needed

Medicare will use the July 2013 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2013, with dates of service July 1, 2013, through September 30, 2013.

Also, Change Request (CR) 8247, from which this article is taken, instructs your Medicare contractors to download and implement the July 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised April 2013, January 2013, October 2012, and July 2012 files.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the 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); see 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 for Dates of Service
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
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012

Additional Information

The official instruction, CR 8247 issued to your FI, carrier, A/B MAC, RHHI or DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2676CP.pdf on the CMS website.

Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch

MLN Matters® Number: MM7260 Revised
Related Change Request (CR) #: CR 7260
Related CR Release Date: March 14, 2013
Related CR Transmittal #: R2670CP
Effective Date: October 1, 2012
Implementation Date: April 1, 2013

Note: This article was revised on March 15, 2013, to reflect a revised Change Request (CR). The revised CR restores the Common Working File (CWF) entitlement validation criterion (in bold below) used prior to the implementation of CR 7260 (October 1, 2012). The implementation date for CR 7260 was changed to April 1, 2013.The Transmittal Number, CR release date, and web address of the CR also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

If Medicare systems reject a claim when there is a mismatch of the Health Insurance Claim Number (HICN) with the beneficiary's personal characteristics (such as name, sex or date of birth), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use Reason Code 140 (Patient/Insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

Additional Information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2670CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

New HCPCS Codes for Customized Durable Medical Equipment

MLN Matters® Number: MM8158
Related Change Request (CR) #: CR 8158
Related CR Release Date: May 6, 2013
Related CR Transmittal #: R1232OTN
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs), other providers, and Durable Medical Equipment (DME) suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), Part A Medicare Administrative Contractors (A MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

Effective July 1, 2013, the Centers for Medicare & Medicaid Services (CMS) is adding three new Healthcare Common Procedure Coding System (HCPCS) codes for payment of customized D M E.

Change Request (CR) 8158, from which this article is taken, announces the addition of the following HCPCS codes to the HCPCS code set:

- K0008 (Custom Manual Wheelchair/Base);
- K0013 (Custom Motorized/Power Wheelchair Base); and
- K0900 (Custom Durable Medical Equipment, Other Than Wheelchairs).

Make sure that you only use these codes for items that meet the definition of "customized item" that is used specifically for Medicare payment purposes only. Very few items meet the Medicare regulatory definition of customized items. Effective July 1, 2013, you should bill claims for custom manual wheelchairs, custom power wheelchairs, and all other custom DME that is not a wheelchair base using these respective codes. Claims for items billed using these codes will be manually processed and evaluated to ensure that the item furnished meets the Medicare definition of customized item.

Background

Customized DME Items

Per 42 Code of Federal Regulations (CFR) Section 414.224(a), in order to be considered a customized DME item, a covered item (including a wheelchair) must be: 1) Uniquely constructed or substantially modified for a specific beneficiary according to a physician's description and orders; and 2) So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

For example, a wheelchair that is custom fabricated, or substantially modified, so that it can meet the needs of wheelchair-confined, conjoined twins facing each other is unique and cannot be grouped with any other wheelchair used for the same purpose. It is a one-of-a-kind item, fabricated to meet specific needs.

Conversely, items that: 1) Are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items); or 2) Have been assembled by a supplier, or ordered from a manufacturer, who makes available customized features, modification or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician do not meet the definition of customized items. These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in a wheelchair or other equipment being considered as customized.

CFR Section 414.224(b) further provides that the lump-sum payment made for purchase of the customized item is based on the Medicare contractor's individual consideration and judgment of a reasonable payment amount for each item. The contractor's individual consideration takes into account: 1) Written documentation on the item's costs (including design, fabrication, and assembly costs), including at least the costs of labor (to the extent that they are reasonable) of those actually performing the customization; and 2) The types of materials (to the extent that they are reasonable) used in custom fabricating or substantially modifying an item. The contractor may need to require a detailed description of each phase of the construction process and labor skills needed to fabricate or modify the item in order to determine a reasonable amount.

To facilitate the identification of, and to ensure appropriate payment for, customized DME that meet the criteria described above; CR8158, from which this article is taken, announces that CMS has added three new HCPCS codes to the HCPCS code set, effective July 1, 2013:

- K0008 Custom Manual Wheelchair/Base;
- K0013 Custom Motorized/Power Wheelchair Base; and
- K0900 Custom Durable Medical Equipment, Other Than Wheelchair.

Therefore, effective July 1, 2013, you should bill claims for custom manual wheelchairs using HCPCS code K0008, claims for custom power wheelchairs using HCPCS code K0013, and all other custom DME that is not a wheelchair base using HCPCS code K0900.

Additional Information

The official instruction, CR8158, issued to your Part A MAC or DME MAC regarding this change may be viewed http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1232OTN.pdf the CMS website.

Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters® Number: MM8246
Related Change Request (CR) #: CR 8246
Related CR Release Date: March 15, 2013
Related CR Transmittal #: R2672CP
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affect

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare contractors (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.

What You Need to Know

This article is based on Change Request (CR) 8246 which provides the annual update to Home Health (HH) consolidated billing effective July 1, 2013. CR 8246 adds the following HCPCS codes to the HH consolidated billing therapy code list: G0456 (Negative pressure wound therapy, (e.g., vacuum assisted

drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm).

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see www.ecfr.gov on the Internet) and in the Medicare Claims Processing Manual (Chapter 10, Section 20; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf on the Centers for Medicare & Medicaid Services (CMS) website).

CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

Services appearing on this list (that are submitted on claims to Medicare contractors) will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA), with the exception of the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods.

The following are not subject to HH consolidated billing:

- Therapies performed by physicians,
- Supplies incidental to physician services, and
- Supplies used in institutional settings.

The HH consolidated billing code lists are updated annually to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year.

These new codes were effective January 1, 2013, but were overlooked in the annual HH consolidated billing update published in CR8043 (see the related article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8043.pdf on the CMS website).

The following HCPCS codes are added to the HH consolidated billing therapy code list effective for claims with dates of service on or after July 1, 2013:

- **G0456** – Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters;
- **G0457** – Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm.

Additional Information

The official instruction, CR8246 issued to your DME MACs, FIs, RHHIs, and A/B MACs regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2672CP.pdf on the CMS website.

Revision to CWF and VMS: Reject or Informational Unsolicited Response Edit for DMEPOS Provided During an Inpatient Stay

MLN Matters® Number: MM8172
Related Change Request (CR) #: CR 8172
Related CR Release Date: February 8, 2013
Related CR Transmittal #: R11830TN
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8172 to alert hospitals and DMEPOS suppliers that claims for DMEPOS items to beneficiaries received in a covered inpatient stay are considered an overpayment and may be rejected or line item denied. DMEPOS suppliers are encouraged to review this article in order to avoid potential overpayment situations.

Background

The CMS Recovery Auditor program is responsible for identifying and correcting improper payments in the Medicare Fee-For-Service (FFS) payment process. The claim data used by the Recovery Auditors identified DMEPOS claims for beneficiaries who received DMEPOS items while in an inpatient stay in a hospital. The payments associated with these claims are considered overpayments because Medicare does not allow separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. These claims were related to DME date of service greater than 2 days prior to Part A discharge date or Part A discharge status was not to home. CR8172 will result in the Common Working File (CWF) creation of a line item rejection for these claims if DMEPOS Claim Status is unpaid or a line item IUR if DEMPOS Claim Status is paid. An IUR results in the investigation of the claim by the DME MAC to determine if an overpayment was made.

Key Points

According to the "Medicare Claims Processing Manual," Chapter 20, Section 210, the DMEPOS benefit is meant only for items a beneficiary is using in his or her home:

- For a beneficiary in a Part A inpatient stay, an institutional provider (e.g., hospital) is not defined as a beneficiary's home for DMEPOS, and so Medicare does not make separate payment for DMEPOS when a beneficiary is in the institution. The institution is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

According to the "Medicare Claims Processing Manual," Chapter 20, Section 110.3.1, in some cases, it would be appropriate for a supplier to deliver a medically necessary item of Durable Medical Equipment (DME), a prosthetic, or an orthotic, but not supplies to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home. CMS presumes that the pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter "item") is appropriate when all the following conditions are met:

1. The item is medically necessary for use by the beneficiary in the beneficiary's home;
2. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use;
3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home;
4. The supplier delivers the item to the beneficiary no earlier than two days before the day the facility discharges the beneficiary;

5. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge;
6. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates;
7. The supplier does not claim payment for the item for any day prior to the date of discharge;
8. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery; and
9. The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility), but not to another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home.

According to the "Medicare Claims Processing Manual," Chapter 20, Section 110.3.2 for DMEPOS, the general rule is that the date of service is equal to the date of delivery. Pre-discharge deliveries of items intended for use upon discharge are considered provided on the date of discharge. The following three scenarios demonstrate both the latter rule (when the date of service is the date of discharge) and related exceptions.

1. If the supplier leaves the item with the beneficiary two days prior to the date of discharge, and if the supplier, as a practical matter, need do nothing further to effect the delivery of the item to the beneficiary's home (because the beneficiary or a caregiver takes it home), then the date of discharge is deemed to be the date of delivery of the item. Such date must be the date of service for purposes of claims submission. (This is not an exception to the general DMEPOS rule that the date of service must be the date of delivery. Rather, it recognizes the supplier's responsibility – per condition five above – to ensure that the item is actually delivered to the beneficiary's home on the date of discharge.) No one may bill for the days prior to the date of discharge.
2. If the supplier fits the item to the beneficiary, or trains the beneficiary in its use while the beneficiary is in the facility, but thereafter removes the item and subsequently delivers it to the beneficiary's home, then the date of service must be the date of actual delivery of the item, provided such date is not earlier than the date of discharge.
3. If the supplier leaves the item at the facility and the beneficiary does not take the item home, or a third party does not send it to the beneficiary's home, or the supplier does not otherwise (re)deliver the item to the beneficiary's home on or before the date of discharge, the date of service must not be earlier than the actual date of delivery of the item, i.e., the actual date the item arrives, by whatever means, at the beneficiary's home.

Additional Information

You can find the official instruction, CR8172, issued to your DME MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1183OTN.pdf on the CMS website.

Phase III Electronic Remittance Advice Enrollment Operating Rules

MLN Matters® Number: MM8223
Related Change Request (CR) #: 8223
Related CR Release Date: May 3, 2013
Related CR Transmittal #: R1224OTN
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers enrolling for Electronic Remittance Advice (ERA) with Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHI), A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME MACs)).

What You Need to Know

This article is based on Change Request (CR) 8223, which instructs Medicare contractors on the steps they must take to come into compliance with Phase III ERA Enrollment Operating Rule requirements by October 1, 2013. Contractors must have paper-based ERA enrollment forms in compliance with Attachment 1 of CR 8223 no later than July 1, 2014.

Medicare contractors must update their Electronic Remittance Advice (ERA) Enrollment forms for new enrollments to comply with Attachment 1 of CR 8223. The contractors must comply with the following requirements:

1. Identify a maximum set of standard data elements to be requested from providers for enrollment to receive Electronic Remittance Advice (ERA).
2. Apply "controlled vocabulary" – predefined and authorized terms- for use when referring to the same data element.
3. Use standard data elements to appear on paper enrollment form in a standard format and flow, using consistent data elements and vocabulary as on the electronic form.
4. Use specific information or instruction to providers to assist in manual paper-based ERA enrollment.
5. Offer electronic ERA enrollment.

Background

Section 1104 of the Affordable Care Act requires the Secretary of Health and Human Services to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purpose of financial and administrative transaction.

What You Need to Know about the ERA Enrollment Form

Providers who have a signed ERA Enrollment Form on file with a particular Medicare contractor or Common Electronic Data Interchange (CEDI) are not required to submit a new signed ERA Enrollment Form to the same Medicare contractor or CEDI each time they change their method of electronic billing or begin to use another type of electronic data interchange (EDI) transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another.

Additionally, providers are not required to notify their Medicare contractor or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

Medicare contractors and CEDIs must inform providers that providers are obligated to notify them in writing in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of ERA.

When an Medicare contractor or CEDI receives a signed request from a provider or supplier to accept ERA transactions from or send ERA transactions to a third party, the Medicare contractor or CEDI must verify that an ERA Enrollment Form is already on file for that provider or supplier. The request cannot be processed until both are submitted and issued.

The binding information in an ERA Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that Medicare contractor or CEDI is no longer associated with the Medicare program. Medicare responsibility for ERA oversight and administration is simply transferred in that case to that entity that the Centers for Medicare & Medicaid Services (CMS) chooses to replace that Medicare contractor or CEDI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

Contractors may require a wet signature to be submitted in conjunction with the electronic enrollment. (Note: A wet signature is an original signature on a document that is then scanned and sent by e-mail.)

The document will become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the Medicare contractor, CEDI, or other contractor if designated by CMS. Either party may terminate the arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

Additional Information

The official instruction, CR 8223, issued to your FI, carrier and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1224OTN.pdf on the CMS website.

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will

be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

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

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

CMS E-NEWS

CMS e-NEWS – February 14, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-14-enews.pdf

National Provider Calls

- How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment — Register Now
- End–Stage Renal Disease Quality Incentive Program – Payment Year 2015 Final Rule — Register Now
- Hospital Value–Based Purchasing Fiscal Year 2015 Overview — Registration Now Open

Other Calls, Meetings, and Events

- Don't Miss DMEPOS Competitive Bidding Webinars for All Provider Types in Upcoming Weeks
- Date and Location Changes for Advisory Panel Meeting on Hospital Outpatient Payments

Announcements and Reminders

- Departments of Justice and HHS Announce Record–Breaking Recoveries Resulting from Joint Efforts to Combat Health Care Fraud
- Revalidating your Medicare Enrollment Information
- ICD–10: WEDI's Survey on Industry Progress Now Open

Claims, Pricer, and Code Updates

- 51MUE Adjustment Process for Possible Overpayment

MLN Educational Products Update

- "Federally Qualified Health Center" Text–Only Fact Sheet — Released
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists
- Submit Feedback on MLN Educational Products

CMS e-NEWS – February 21, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-21-enews.pdf

National Provider Calls

- End-Stage Renal Disease Quality Incentive Program – Payment Year 2015 Final Rule – Register Now
- Hospital Value-Based Purchasing Fiscal Year 2015 Overview – Register Now
- Audio Recording and Written Transcript from January 16 Meaningful Use: Stage 1 and Stage 2 Call Now Available
- Audio Recording and Written Transcript from January 31 CMS National Partnership to Improve Dementia Care in Nursing Homes Call Now Available

- Other Calls, Meetings, and Events
- Join the ICD-9-CM Coordination and Maintenance Committee Meeting for an ICD-10 Update

Announcements and Reminders

- Flu Season Isn't Over—Continue to Recommend Vaccination
- ICD-10 MS-DRG FY 2013 Software Now Available
- EHR Incentive Programs: Medicare EP Attestation Reminder and Other Updates
- Now Available: New and Updated FAQs about the EHR Incentive Programs

Claims, Pricer, and Code Updates

- New HCPCS G-code for Pharmacologic Management Service Furnished via Telehealth to Inpatients

MLN Educational Products Update

- New MLN Provider Compliance Fast Fact

CMS e-NEWS – February 28, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-28Enews.pdf

National Provider Calls

- End-Stage Renal Disease Quality Incentive Program – Payment Year 2015 Final Rule – Register Now
- Hospital Value-Based Purchasing Fiscal Year 2015 Overview – Register Now
- 2013 PQRS and eRx Claims-Based Reporting Made Simple – Save the Date

Announcements and Reminders

- FDA Alerts Dialysis Centers of Recall of Anemia Drug Omontys
- New Short-Term Acute Care Program for Evaluating Payment Patterns Electronic Report Released
- EPs Can Use New Interactive Resource to Determine Timeline for Participation in the EHR Incentive Programs
- CMS Releases ICD-10 Checklists and Timelines
- Plan to Mitigate Risk for a Smooth ICD-10 Transition

Claims, Pricer, and Code Updates

- Revised 2013 Purchase Diagnostic Test Payment File

MLN Educational Products Update

- "Quick Reference Information: Home Health Services" Educational Tool – Released
- "The Medicare Fee-For-Service Recovery Audit Program Process" Educational Tool – Released
- "Critical Access Hospital" Fact Sheet – Revised
- "Ambulatory Surgical Center Fee Schedule" Fact Sheet – Revised
- "Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training" Web-Based Training Course – Revised
- "Providing the Annual Wellness Visit" Booklet – Reminder
- "Screening and Diagnostic Mammography" Booklet – Reminder
- "Screening Pelvic Examinations" Booklet – Reminder
- "Preventive Immunizations" Booklet – Reminder
- New MLN Educational Web Guides Fast Fact

CMS e-NEWS – March 7, 2013

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-07-eNews.pdf

National Provider Calls

- End-Stage Renal Disease Quality Incentive Program – Payment Year 2015 Final Rule – Register Now
- Hospital Value-Based Purchasing Fiscal Year 2015 Overview – Register Now
- 2013 PQRS and eRx Claims-Based Reporting Made Simple – Save the Date
- Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and
- Part A Home Health Agency Claims – Save the Date

Announcements and Reminders

- Flu Activity Continues: Prompt Antiviral Treatment is Crucial for Seniors Sick with Flu
- Hospice Quality Reporting Program Requirements for Payment Years 2014 and 2015
- Quality Reporting Communication Support Page Now Available for Medicare eRx 2014 Payment
- Adjustment Hardship Exemption Requests

Claims, Pricer, and Code Updates

- Edits for Ordered/Referred Services Will Be Turned On May 1
- Status of Reprocessing Hospital Value-Based Purchasing Program Claims
- Problem Impacting Crossover of Medicare Part B Outpatient Therapy Claims
- April 2013 Average Sales Price Files Now Available

MLN Educational Products Update

- "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article – Released
- "2013 Medicare Part C and Part D Reporting Requirements Data Validation" Web-Based Training Course – Released

CMS e-NEWS – March 14, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-14-eNews.pdf

National Provider Calls

- 2013 PQRS and eRx Claims-Based Reporting Made Simple – Registration Now Open
- Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and Part A Home Health Agency Claims – Registration Now Open
- Video Slideshow Presentation from January 31 Call on the CMS National Partnership to Improve Dementia Care in Nursing Homes Now Available

Announcements and Reminders

- Colorectal Cancer is Preventable and Treatable – Your Recommendation Can Help Save Lives
- Are you ready for DMEPOS Competitive Bidding?
- CDC and CMS Sound Alarm on "Nightmare" Bacteria
- HHS Announces 2013 Agenda to Bring Down Costs and Improve Quality of Care Through Implementation of Health Information Technology

- Notice Issued on Extension of the Low-Volume Hospital Payment Adjustment and the Medicare – Dependent Hospital Program
- Recovery Auditors Shall Not Issue Any "Failure to Respond" Denials to esMD Providers
- Hospice Quality Reporting Program: NQF #0209 Deadline April 1
- CMS Continues Efforts to Improve Quality of Care for People with Medicare
- Several New and Updated EHR FAQs Added to CMS Database

MLN Educational Products Update

- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet – Revised
- "Power Mobility Devices (PMDs)" Fact Sheet – Revised

CMS e-NEWS – March 21, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-21-e-News.pdf

National Provider Calls

- Medicare Shared Savings Program Application Process – Registration Now Open
- PQRS Group Practice Reporting Option and Registry Reporting – Save the Date
- Begin Transitioning to ICD-10 in 2013 – Registration Now Open
- Transcript and Audio File from February 19 Call on How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment Now Available

Other Calls, Meetings, and Events

- Physician Compare Redesign Open Door Forum Registration

Announcements and Reminders

- It's National Nutrition Month
- DMEPOS Competitive Bidding Video Slideshow Now Available
- Proposed Rule and Administrator Ruling Released for Part B Inpatient Billing in Hospitals
- Request for Information on the Use of Clinical Quality Measures Reported Under the PQRS and EHR Incentive Program – Comment Period Ends April 8
- CMS to Release a Comparative Billing Report on Evaluation and Management Services – Target Release March 22
- NQF #0209 Deadline for the Hospice Quality Reporting Program is April 1
- ICD-10 News: Updated Implementation Guides

Claims, Pricer, and Code Updates

- January Quarterly Inpatient Provider Specific File for the Prospective Payment System Available

MLN Educational Products Update

- "Update on the Medicare Hospice Quality Reporting Program (HQRP)" MLN Matters® Article – Released
- Updated DMEPOS Competitive Bidding Fact Sheets for Round 2
- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet – Revised
- "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet – Revised
- "Medicare Billing: 837I and Form CMS-1450" Fact Sheet – Revised

- Pilot Testers Needed
- New MLN Educational Web Guides Fast Fact
- New MLN Provider Compliance Fast Fact

CMS e-NEWS – March 28, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-28-enews.pdf

National Provider Calls

- Medicare Shared Savings Program Application Process – Register Now
- PQRS Group Practice Reporting Option and Registry Reporting – Registration Now Open
- Begin Transitioning to ICD-10 in 2013 – Register Now

Other Calls, Meetings, and Events

- Physician Compare Redesign Open Door Forum Registration

Announcements and Reminders

- Mandatory Payment Reductions in the Medicare FFS Program – "Sequestration"
- CMS to Begin Accepting Suggestions for Potential PQRS Measures and Measures Groups in May
- Frequently Asked Questions About Billing Medicare for Transitional Care Management Services Available
- Have You Tried the CMS Medicare Physician Fee Schedule Search Tool?
- New Release of PEPPER for LTCHs, CAHs, IPFs, IRFs, Hospices and PHPs
- NQF #0209 Deadline for the Hospice Quality Reporting Program is Monday, April 1
- EHR Incentive Programs: New Interactive Resource on Stage 2 and the 2014 CQMs

Claims, Pricer, and Code Updates

- Manual Medical Review of Outpatient Therapy Claims Will Begin April 1
- New Remittance Advice Message for Therapy Claims
- Quarterly Provider Specific Files for the Prospective Payment System Updated

MLN Educational Products Update

- "DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers" Fact Sheet – Revised
- "DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet – Revised
- "The Medicare Appeals Process" Fact Sheet – Revised
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Revised
- "Clarification for Billing Part B versus Part D for the Anti-emetic Aprepitant (Emend®)" MLN Matters® Article – Reminder

CMS e-NEWS – April 4, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-04-Enews.pdf

National Provider Calls

- Medicare Shared Savings Program Application Process – Register Now

- PQRS Group Practice Reporting Option and Registry Reporting – Register Now
- Begin Transitioning to ICD-10 in 2013 – Register Now
- ESRD Low-Volume Payment Adjustment – Registration Now Open
- Transcript and Audio File from March 19 2013 PQRS and eRx Claims-based Reporting Made Simple Call Now Available

Announcements and Reminders

- Medicare Provides Coverage to Reduce Alcohol Misuse
- CMS Releases 2011 PQRS and eRx Incentive Program Experience Report – Data Shows Gains in Participation
- New and Updated EHR FAQs Recently Added to CMS FAQ Database
- CMS Posts 2014 Eligible Hospital Clinical Quality Measure Update

Claims, Pricer, and Code Updates

- Hold for IPPS Claims with Technology Add-on Payments
- Do Not Include Middle Names and Suffixes of Ordering/Referring Providers on Claims
- Effect of Ordering and Referring Denial Edits on the Technical and Professional Component of Imaging Services

MLN Educational Products Update

- "Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)" MLN Matters® Article – Released
- "The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Traveling Beneficiary" Fact Sheet – Revised
- "The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies" Fact Sheet – Revised

CMS e-NEWS – April 11, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-11-Enews.pdf

National Provider Calls

- PQRS Group Practice Reporting Option and Registry Reporting – Register Now
- Begin Transitioning to ICD-10 in 2013 – Register Now
- Medicare Shared Savings Program Application Process: Tips on Completing a Successful Application – Register Now
- ESRD Low-Volume Payment Adjustment – Register Now
- Transcript and Audio File from March 13 2013 ESRD Quality Incentive Program – Payment Year 2015 Final Rule Call Now Available
- Transcript and Audio File from March 14 HVBP FY 2015 Overview National Provider Call Now Available

Announcements and Reminders

- LTCH Quality Reporting Program Requirements for FY 2014 and 2015
- CDC Message to Health Care Providers: Ordering Flu Vaccine for 2013-2014
- CMS to Begin Accepting Suggestions for Potential PQRS Measures and Measures Groups in May
- What Providers Need to Know about EHR Audits
- Read Updated EHR FAQ for Eligible Professionals on Selecting Menu Objectives

MLN Educational Products Update

- "The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet – Revised
- "The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers" Fact Sheet – Revised
- "A Physician's Guide to Medicare Part D Medication Therapy Management Programs" Podcast – Released
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists
- Submit Feedback on MLN Educational Products

CMS e-NEWS – April 18, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-18Enews.pdf

National Provider Calls

- Medicare Shared Savings Program Application Process: Tips on Completing a Successful Application — Last Chance to Register
- ESRD Low-Volume Payment Adjustment — Last Chance to Register

Other Calls, Meetings, and Events

- CMS and ONC Meeting About EHRs, Coding, and Billing

Announcements and Reminders

- Prepare to Help Your Patients Navigate the New Health Insurance Marketplace on October 1
- New OPEN PAYMENTS Resources Now Available Online: Updated Website and Continuing Medical Education Activity
- HQRP 2013 Deadlines Have Passed: Next HQRP Data Submission will be April 1, 2014
- Mandated Sequestration Payment Reductions Beginning for Medicare EHR Incentive Program

Claims, Pricer, and Code Updates

- April 2013 Claim Hold Lifted
- Interim Process for Hospitals to Bill Part B Services Following Denial of an Inpatient Admission as not Reasonable and Necessary
- Outpatient Therapy Services Functional Reporting Testing Period — Now in Effect
- Temporary Bypass of Common Working File Qualifying Stay Edit C7123 for All SNF and SB Claims
- Quarterly Provider Specific Files for the Prospective Payment System are Now Available
- CY 2013 Outpatient PPS Pricer and Provider File Update
- Modifications to the HCPCS Code Set Posted
- IPF PPS PC Pricer Updated with January 2013 Provider Data
- Updated PC Pricer Download Instructions

CMS e-NEWS – April 25, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-25Enews.pdf

National Provider Calls

- Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series – Save the Date

- Audio Recording and Written Transcript from April 9 "Medicare Shared Savings Program Application Process: Preparing to Apply" Call Now Available

Announcements and Reminders

- Advancing Health Equality for All
- Temporary Delay in Implementing Ordering and Referring Denial Edits
- Major Improvements to the Internet-based PECOS System
- Internet –Based PECOS Tutorials and Resources
- CMS to Begin Accepting Suggestions for Potential PQRS Measures and Measures Groups in May
- LTCH FY 2014 Data Submission Due May 15

Claims, Pricer, and Code Updates

- Interim Process for Hospitals to Bill Part B Services Following Denial of an Inpatient Admission as Not Reasonable and Necessary – Temporary Instructions Revised
- Inpatient PPS PC Pricer Update
- Home Health PPS PC Pricer Update
- Inpatient Psychiatric Facility PPS PC Pricer Update
- Inpatient Rehabilitation Facility PPS PC Pricer Update

MLN Educational Products Update

- "Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Competitive Bidding Program: Non-Contract Supplier" Fact Sheet – Revised
- New MLN Provider Compliance Fast Fact

CMS e-NEWS – May 2, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-02-Enews.pdf

National Provider Calls

- National Physician Payment Transparency Program (OPEN PAYMENTS) – What You Need To Know – Registration Now Open
- Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series – Save the Date
- Audio Recording and Written Transcript from April 18 "Begin Transitioning to ICD-10 in 2013" Call Now Available

Other Calls, Meetings, and Events

- Data.Medicare.Gov: Get Started Webinar

Announcements and Reminders

- CMS Proposes Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit
- A Record of Progress on Health Information Technology
- CMS Proposes New Safeguards and Incentives to Reduce Medicare Fraud
- FAQs Available for Revised and Clarified Place of Service Coding Instructions Effective April 1
- June 30 Deadline to Avoid 2014 eRx Payment Adjustment
- National Partnership to Improve Dementia Care in Nursing Homes Working to Reduce Percentage of Long-Stay Residents Receiving Antipsychotic Medication

CMS E-NEWS

- CMS Announces Teaching Hospital Closure and Round 4 of Section 5506 of the Affordable Care Act
- Updated EHR FAQs: Information on Sequestration and Guidance on Attestation
- ICD-10: Assessing Your Vendors

Claims, Pricer, and Code Updates

- Additional Provider Communication Regarding Automatic Adjustments for Erroneous Medically Unlikely Denials
- Billing for Transitional Care Management Services in Rural Health Clinics and Federally Qualified Health Centers
- TOB 85X Medically Unlikely Edit Claims Adjudication Change
- Inpatient Prospective Payment System PC Pricer Updated

MLN Educational Products Update

- "Medicare Billing Information for Rural Providers and Suppliers" Booklet – Revised
- "Medicare Remit Easy Print Software" Fact Sheet – Revised
- "Questionable Billing By Suppliers of Lower Limb Prostheses" MLN Matters® Article – Revised
- "HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" MLN Matters® Article – Revised

COMPETITIVE BIDDING

DMEPOS Contract Suppliers Announced

CMS has announced the contract suppliers for Round 2 and the national mail-order program of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

A list of contract supplier names is available at www.dmecompetitivebid.com. Contract supplier locations for each product category in each competitive bidding area can be found in the Supplier Directory at www.medicare.gov/supplier.

For additional information:

- Press Release
- Fact Sheet

New Name for CBIC Ombudsmen

CMS is changing the name of the Competitive Bidding Implementation Contractor (CBIC) ombudsmen to CBIC liaisons. This change will help distinguish the CBIC liaisons from the CMS Competitive Acquisition Ombudsman. The CBIC liaisons are now available to assist suppliers, referral agents, and other key stakeholders with questions and concerns about the program, provide assistance locating contract suppliers, and participate in educational events. There is a dedicated CBIC liaison assigned in each of several regional geographic territories consisting of Round 1, Round 2, and National Mail-Order competitive bidding areas. A list of CBIC liaisons and their contact information is available at www.dmecompetitivebid.com under 'Contact Us.'

DMEPOS National Competitive Bidding: Using "KY" Modifier to Bill for Accessories for Non-CB wheelchair Base Units

MLN Matters® Number: MM8181
Related Change Request (CR) #: CR 8181
Related CR Release Date: February 8, 2013
Related CR Transmittal #: R1184OTN
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for standard power wheelchair and manual wheelchair accessories furnished for use with non-competitively bid wheelchair base units to Medicare beneficiaries who permanently reside in a Round 2 (or subsequent Round) competitive bid area (CBA).

Provider Action Needed

This article is based on Change Request (CR) 8181 and alerts suppliers to the requirement to use the "KY" modifier when billing for competitively bid (Round 2 or subsequent Round) wheelchair accessories used with certain non-competitively bid wheelchair base units for beneficiaries residing in Round 2 (or subsequent Round) CBAs. The "KY" modifier is used with accessory codes that are used with complex rehabilitative power wheelchair bases that are not Round 2 (or subsequent Round) competitive bid items, but were bid in Round 1 of the DMEPOS Competitive Bidding Program.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new Competitive Bidding Program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas (CBA), and the Centers for Medicare & Medicaid Services (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.

CMS is required by law to re-compete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except mail-order diabetic supplies expires on December 31, 2013.

Standard Power Wheelchairs and Manual Wheelchairs are included in the Round 2 Standard (Power and Manual) wheelchairs, scooters, and related accessories product category. Since some of the accessories included in this product category can also be used with non-competitively bid wheelchair base units, a supplier providing an accessory for a non-competitively bid wheelchair base unit to a beneficiary who permanently resides in a CBA will need to use the "KY" pricing modifier in order for the claim to process correctly.

Since MIPPA mandated a 9.5% fee schedule reduction for items included in Round 1 of the Competitive Bidding Program, the "KE" modifier was used to differentiate wheelchair accessory codes used with both competitive bid and non-competitive bid wheelchair base units.

The "KE" modifier identifies accessories used with a non-competitive bid base unit and for which payment is not subject to the fee schedule reduction.

See below for Round 2 accessory billing scenarios that are based on the types of wheelchair bases that the accessory is used with and the competitive bid status of the base unit.

Under Round 2

Chair Bases bid: Manual (K1, K2, K3, K4, K6, K7) and standard P MDs

Example: billing accessory code E0950

Accessory Code E0950 used with a:	Base Code Competitive Bid Status	Claim for a Beneficiary who Permanently Lives in a CBA	Payment Basis in CBA	Claim for a Beneficiary who Permanently Lives Outside a CBA	Payment Basis Outside CBA
Manual Wheelchair (K0001- K0004, K0006, K0007)	Bid in Round 2; (not bid in Round 1)	Bill without KE or KY modifier	Single Payment Amount (SPA)	Bill with KE modifier	Fee Schedule**
Standard Power Wheelchair (K0813 thru K0829)	Bid in Round 2 (bid in Round 1)	Bill without KE or KY modifier	SPA	Bill without KE modifier	Fee Schedule*
Complex Rehabilitative Group 2 Power Wheelchair (K0835 thru K0843) and Complex Rehabilitative Group 3 Power Wheelchair (K0848 thru K0864)	Not bid in Round 2 (bid in Round 1)	Bill with KY modifier	Fee Schedule*	Bill without KE modifier	Fee Schedule*
Manual Wheelchair (K0005, K0009) or Miscellaneous Power Wheelchair (K0898)	Not bid in Round 2 (not bid in Round 1)	Bill with KE modifier	Fee Schedule**	Bill with KE modifier	Fee Schedule**

* Fee schedule amount includes the 9.5% reduction.

** Fee schedule amount includes the 5% covered item update increase.

Claims Processing Rules Summary

Covered claims will be paid for competitively bid (Round 2 or subsequent Round) wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with certain non-competitively bid wheelchair base units at the fee schedule rate, when billed by a non-contract supplier with a "KY" modifier.

Claims will be denied for competitively bid (Round 2 or subsequent Round) wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with certain non-competitively bid wheelchair base units, when billed by a non-contract supplier without a "KY" modifier.

The following Claims Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), and Group Code will be used on the remittance advice when a claim is denied by the DME MAC:

- CARC 4: The procedure code is inconsistent with the modifier use or a required modifier is missing.
- CARC 16: Claim/service lacks information which is needed for adjudication.
- RARC M114: This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
- RARC MA13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code.
- RARC N519: Invalid combination of HCPCS modifiers.
- RARC N565: Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.
- Group Code: CO

In addition, Medicare will return claims as unprocessable when the KY modifier is submitted by a supplier for accessory items for beneficiaries in a CBA for wheelchairs that are not identified by the HCPCS ranges of K0835-K0843 and K0848-K0864. In returning such claims, Medicare will use:

- CARC 4: The procedure code is inconsistent with the modifier use or a required modifier is missing.
- RARC M114: This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
- RARC MA13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code.
- 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/corrected information.
- Group Code: CO

Additional Information

The official instruction, CR8181 issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1184OTN.pdf on the CMS website.

National Competitive Bidding Program: Instructions for Processing CBP Oxygen and Capped Rental DME Claims with the Start of the Round One Recompete

MLN Matters® Number: MM8270
Related Change Request (CR) #: CR 8270
Related CR Release Date: May 3, 2013
Related CR Transmittal #: R1219OTN
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) suppliers who submit oxygen and capped rental DME claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for DME rental items and oxygen supplies provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8270 which implements claims processing rules for grandfathering policies for oxygen and capped rental DME included in the Round One Recompete of DMEPOS (CBP).

Background

Section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Modernization Act" or "MMA") established requirements for a new Competitive Bidding Program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 Metropolitan Statistical Areas (MSAs) in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS successfully conducted the supplier competition again in nine areas in 2009, referring to it as the Round 1 Rebid. The Round 1Rebid 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 of 2010 (ACA) 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 are scheduled to go into effect on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round 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.

DMEPOS CBP Round One Recompete

CR8270 updates the claims processing rules to apply the grandfathering policies for oxygen and capped rental items included in the Round One Recompete of the DMEPOS CBP. As of January 1, 2014, when the Round One Recompete contracts and prices become effective, all contracts from the Round One Rebid will be expired.

As of that date, Round One Rebid suppliers are considered to be non-contract suppliers for the Round 1 CBAs unless they won contracts for the Round One Recompete. Non-contract suppliers that furnish rented durable medical equipment or oxygen may choose to become grandfathered suppliers and continue to rent DME to beneficiaries they are servicing when the program becomes effective. Beneficiaries have the choice to remain with their current supplier (if that supplier opts to become a grandfathered supplier or is a contract supplier) or to switch to a contract supplier.

Note: If a beneficiary (who would have been entitled to obtain items from a grandfathered supplier) switches to a contract supplier, the contract supplier is eligible to receive additional rental payments as provided in 42 CFR 414.408. See www.ecfr.gov on the Internet.

Grandfathering Provision

The Social Security Act (Section 1847(a)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the Internet) requires that CMS establish a "grandfathering" process by which the rental agreement for those covered items and supply arrangements with oxygen suppliers entered into before the start of a competitive bidding program may be continued in the case of:

1. Covered DME items for which payment is made on a rental basis under the Social Security Act (Section 1834(a)); and
2. Oxygen for which payment is made under the Social Security Act (Section 1834(a)(5)).

This grandfathering provision provides the beneficiary the choice of receiving a grandfathered item from a grandfathered supplier or a contract supplier. In the event that a beneficiary no longer rents a grandfathered item from his or her previous supplier (because the previous supplier elected not to become a grandfathered supplier or the beneficiary elected to change suppliers), the new contract supplier will receive a certain number of additional monthly payments for furnishing the non-grandfathered item, regardless of how many payments Medicare previously made to the prior supplier.

In the case of capped rental DME, the new contract supplier will receive 13 additional monthly payments for the DME, provided the DME remains medically necessary. For oxygen equipment, the new contract supplier will receive at least 10 monthly rental payments. For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months 2 through 26, Medicare would make payment for the remaining number of rental months in the 36-month rental period. However, should a contract supplier begin furnishing oxygen equipment to a beneficiary in months 27 through 35, Medicare would make 10 additional rental payments provided the equipment remains medically necessary. For oxygen equipment, the maximum number of payments may not exceed 45 rental payments

Scenarios

The following section describes possible scenarios for capped rental DME furnished during the Round One Recompete and subsequent rounds of the CBP:

Scenario 1 – The beneficiary was receiving items or services from a Round One Rebid contract supplier that was awarded a contract for the Round One Recompete and the beneficiary chooses to stay with that supplier.

In this case the supplier IS NOT ENTITLED to any additional payments since the beneficiary is not otherwise entitled to obtain the items from a grandfathered supplier.

Scenario 2 – The beneficiary was receiving items or services from a Round One Rebid contract supplier that was not awarded a contract for the Round One Recompete and the beneficiary chooses to switchto a Round One Recompete contract supplier.

In this case, the new contract supplier IS ENTITLED to the additional payments since the beneficiary is eligible to obtain the items from a grandfathered supplier.

Scenario 3 – The beneficiary was receiving items or services from a Round One Rebid contract supplier that was not awarded a contract for the Round One Recompete but opted to become a grandfathered supplier, and the beneficiary chooses to remainwith the grandfathered supplier.

In this case, the grandfathered supplier IS NOT ENTITLED to additional payments since only contract suppliers are eligible for additional payments.

Scenario 4 – The beneficiary was receiving items or services from a Round One Rebid contract supplier that was awarded a contract for the Round One Recompete and the beneficiary chooses to switchto a new contract supplier.

In this case, the contract supplier IS NOT ENTITLED to the additional payments since the beneficiary is not otherwise entitled to obtain the items from a grandfathered supplier.

Additional Information

You can find out more about DMEPOS Competitive Bidding Program at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

The official instruction, CR 8270 issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1219CP.pdf on the CMS website.

Quarterly Update for DMEPOS Competitive Bidding Program – July 2013

MLN Matters® Number: MM8232
Related Change Request (CR) #: CR 8232
Related CR Release Date: April 5, 2013
Related CR Transmittal #: R2682CP
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8232 to provide the DMEPOS July 2013 quarterly update. Change Request (CR) 8232 provides specific instructions for implementing updates to the DMEPOS Competitive Bidding Program (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 competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS awards payment amounts resulting from the competition to 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 Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in Competitive Bidding Areas (CBA) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando- Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related

Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

MIPPA required the competition for Round Two to occur in 2011 in 70 additional Metropolitan Statistical Areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program 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 Round Two and National Mail Order information, the latest product categories in the CBP, single payment amounts, and the ZIP codes of areas impacted by the CBP.

Updates to the ZIP Code Files

Ten new ZIP codes have been added to the ZIP code file to conform with United States Postal Service ZIP code changes within CBAs:

ZIP	CBA	
64162	28140	Kansas City, MO-KS -- Non Mail-Order
22350	20530	Washington-Arlington-Alexandria, DC-VA-MD-WV
31144	20075	Atlanta-Sandy Springs-Marietta, GA
35270	20110	Birmingham-Hoover, AL
40166	20290	Louisville/Jefferson County, KY-IN
46197	20250	Indianapolis-Carmel, IN
46213	20250	Indianapolis-Carmel, IN
56999	20530	Washington-Arlington-Alexandria, DC-VA-MD-WV
72255	20280	Little Rock-North Little Rock-Conway, AR
80038	20185	Denver-Aurora-Broomfield, CO
84129	20430	Salt Lake City, UT

Additional Information

The official instruction, CR 8232, issued to your RHHI or DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2682CP.pdf on the CMS website.

MLN Matters® Article SE1244 is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on the Medicare DMEPOS Competitive Bidding Program at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1244.pdf on the CMS website.

You may review the fact sheet designed to outline the requirements related to providing mail order diabetic supplies to beneficiaries who reside in a CBA as well as information detailing options for purchasing diabetic supplies on a non-mail order basis at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Mail_Order_Factsheet_ICN900924.pdf on the CMS website.

Third Quarter Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (HCPCS E0601)

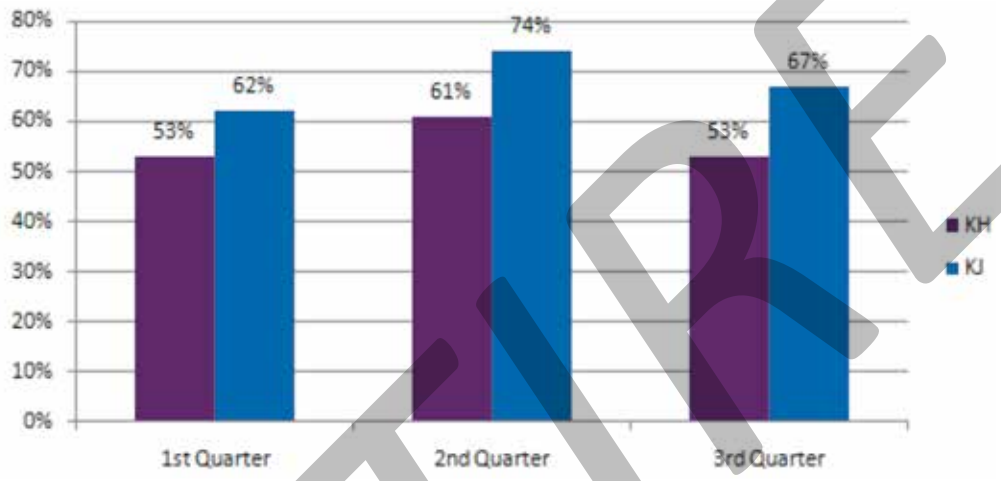
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0601 for the first month of billing (KH modifier) and the 4th thru 13th month of billing (KJ modifier). The third quarter edit effectiveness results from November 2012 through January 2013 are as follows:

The KH modifier review involved 2,079 claims of which 1069 were denied. This resulted in an overall error rate of 53%.

The KJ modifier review involved 1055 claims of which 669 were denied. This resulted in an overall error rate of 67%.

Historical Data of the Error Rate for KH and KJ Review



Primary Documentation Errors that Resulted in Denial of Claims

15% of KJ claims received a denial as 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.

15% of KH claims received a denial as Criteria A was not met.

10% of KJ claims received a denial as Criteria A was not 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)

14% of KJ claims received a denial as criteria one was not met for continued coverage beyond first three months

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;

11% of KH claims received a denial as signature requirements not met.

7% of KJ claims received a denial as signature requirements not met.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author per PIM 3.3.2.4.

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea on the Noridian website at https://www.noridianmedicare.com/dme/coverage/resources/pap_devices.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

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

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

DOCUMENTATION

Physician Documentation Responsibilities

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

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

Billing Reminder – Units of Service for OACD

Oral Anticancer drugs (OACD) have unique billing requirements. Recently errors in billing for these drugs have been identified. Suppliers are reminded:

- Only the drugs listed in the policy are covered. The oral anticancer drugs that are addressed in this policy are:
  - Busulfan
  - Capecitabine
  - Cyclophosphamide
  - Etoposide
  - Fludarabine phosphate
  - Melphalan
  - Methotrexate
  - Temozolomide
  - Topotecan
- National Drugs Codes (NDCs) may be billed only when the drug is used as an oral anticancer drug.
- For all NDC numbers, 1 unit of service = 1 tablet or 1 capsule.
- Suppliers must use the NDC that matches the product dispensed.
- HCPCS J codes for these drugs must not be used when billing for these drugs
- Under the Metric Decimal Quantity and the Billing Unit Standard for NCPDP, solid oral dosage forms (tablets, capsules, etc.) are billed as "each" i.e., 1 unit of service = 1 tablet or 1 capsule each
- Under no circumstances should the number of grams, milligrams, etc. be used for the UOS

Refer to the LCD, related Policy Article and Supplier Manual for additional information about coverage, documentation and billing for these items.

Oral Anti-Cancer Drugs – Coding and Billing Change

Recently suppliers have raised questions about the proper billing of oral anti-cancer drugs (OACDs). Questions related to the use of the Pricing, Data Analysis and Coding (PDAC) contractor listing of OACDs and NDC codes. Effective May 1, 2013, instructions for determining the proper NDC code are changed.

According to the current OACD Local Coverage Determination Related Policy Article Coding Guidelines section:

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

Previous education instructed suppliers to use the PDAC "Oral Anticancer Drug (OACD)" list to determine the covered drugs and proper NDC code for billing. This list is updated on a quarterly basis. In some cases, new NDC codes are added to the market but may not yet appear on the PDAC OACD list resulting in the requirement to use miscellaneous code J8999.

Effective May 1, 2013, the Coding Guidelines will instruct suppliers to reference the PDAC "NDC/HCPCS Crosswalk" and no longer reference the PDAC OACD list. NDC numbers for covered oral anticancer drugs are included on the NDC/HCPCS list. This list is updated monthly and should be referred to for appropriate coding of OACDs. Until a new NDC number is added to the list in the monthly update, suppliers have two options:

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

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

Suppliers should refer to the OACD LCD and Related Policy Article and Supplier Manual for additional coverage, coding and documentation requirements.

Quarterly HCPCS Drug/Biological Code Changes – July 2013 Update

MLN Matters® Number: MM8286
Related Change Request (CR) #: CR 8286
Related CR Release Date: May 2, 2013
Related CR Transmittal #: R2695CP
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8286 which informs Medicare contractors about the updating of specific drug and biological HCPCS codes which occurs quarterly. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Key Points of CR8286

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will no longer be payable for Medicare:

- J3487: Injection, Zoledronic Acid (Zometa), 1mg.
- J3488: Injection, Zoledronic Acid (Reclast), 1mg.
- J9002: Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10mg.
- Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will be payable for Medicare:
- Q2033: Influenza Vaccine, Recombinant Hemagglutinin Antigens, For Intramuscular Use (Flublok).
- Q2050: Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg.
- Q2051: Injection, Zoledronic Acid, not otherwise specified, 1mg.

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS code will be accepted on claims, but not payable by Medicare:

- Q0090: Levonorgestrel-Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg.

Additional Information

The official instruction, CR8286 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2695CP.pdf on the CMS website.

Results of Widespread Prepayment Probe Review of Oral Anticancer Drugs (Temozolomide 5 mg, 20 mg and Capecitabine 150 mg, 500 mg)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of Temozolomide 5 mg, 20 mg and Capecitabine 150 mg, 500 mg. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The Temozolomide 5 mg, 20 mg review involved 100 claims of which 82 were denied. This resulted in an overall error rate of 79%.

The Capecitabine 150 mg, 500 mg review involved 100 claims of which 76 were denied. This resulted in an overall error rate of 74%.

Primary Documentation Errors that Resulted in Denial of Claims

- 49% of Capecitabine 150 mg, 500 mg claims received a denial as there was no/invalid refill request.
- 31% of Temozolomide 5 mg, 20 mg claims received a denial as there was no/invalid refill request.

REFILL REQUIREMENTS

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 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.
- 10% of Capecitabine 150 mg, 500 mg claims received a denial as the proof of delivery was after the date of service on the claim.
- 7% of Temozolomide 5 mg, 20 mg claims received a denial as the proof of delivery was after the date of service on the claim.

PROOF OF DELIVERY

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

Going Forward

Noridian will close this probe review.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Oral Anticancer Drugs Local Coverage Determination (LCD) L11574 and Policy Article A25372.

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

Sixth Quarter 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 sixth quarter edit effectiveness results from December 2012 through March 2013 are as follows:

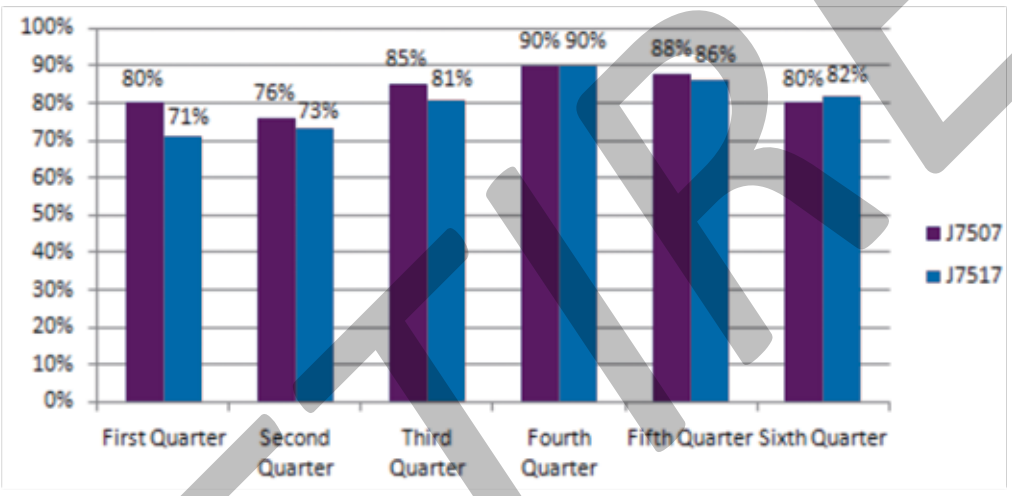
The J7507 review involved 4,023 claims of which 1,980 were denied. This resulted in an overall error rate of 80%.

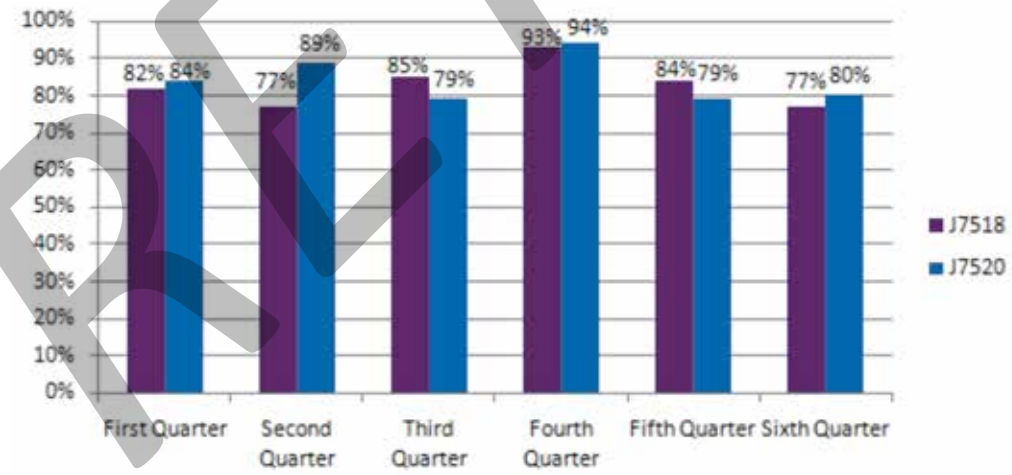
The J7517 review involved 2,497 claims of which 1,257 were denied. This resulted in an overall error rate of 82%.

The J7518 review involved 1,141 claims of which 884 were denied. This resulted in an overall error rate of 77%.

The J7520 review involved 371 claims of which 293 were denied. This resulted in an overall error rate of 80%.

Historical Data of the Error Rate for J7507, J7517, J7518 and J7520 Review





Primary Documentation Errors that Resulted in Denial of Claims

- **49% of J7507 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.**
- **50% of J7517 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.**
- **49% of J7518 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.**
- **44% of J7520 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.**

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.

- **23% of J7507 claims received a denial as there was no/invalid refill request.**
- **23% of J7517 claims received a denial as there was no/invalid refill request.**
- **22% of J7518 claims received a denial as there was no/invalid refill request.**
- **23% of J7520 claims received a denial as there was no/invalid refill request.**

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 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.

- **9% of J7507 claims received a denial as there was invalid proof of delivery.**
- **8% of J7517claims received a denial as there was invalid proof of delivery.**
- **10% of J7518 claims received a denial as there was invalid proof of delivery.**
- **11% of J7520 claims received a denial as there was invalid proof of delivery.**

Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for seven years. Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12). Proof of delivery documentation must be made available to the DME MAC, DME PSC, and ZPIC upon request.

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

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

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.

- **7% of J7507 claims received a denial as there was no written or verbal order.**
- **7% of J7517 claims received a denial as there was no written or verbal order.**
- **6% of J7518 claims received a denial as there was no written or verbal order.**
- **6% of J7520 claims received a denial as there was no written or verbal order.**

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

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 Immunosuppressive Drugs Local Coverage Determination (LCD) L68 and Policy Article A25366.

DRUGS/BIOLOGICALS

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

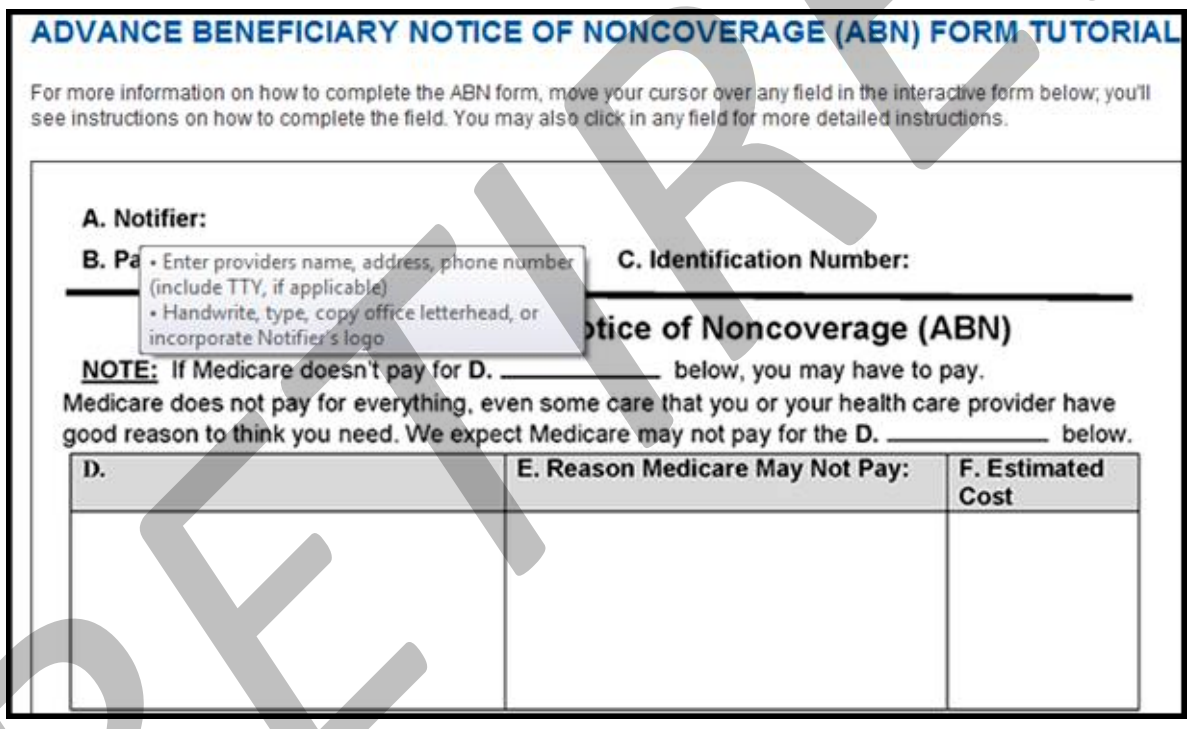
EDUCATIONAL

ABN Instructions and Tutorial – Now Available

The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories), physicians, practitioners, and suppliers to Original Medicare (Fee For Service) beneficiaries in situations where Medicare payment is expected to be denied.

To assist providers/suppliers with completing the ABN, we have published the ABN instructions and created an ABN Tutorial. To view short completion tips, move your cursor over any field within the form. If you wish to read more detailed instructions, click on the desired field.

Example displayed in image below.



DME ABN information is located on the ABN "Consolidated Resources" page of "Training/Events"

- https://www.noridianmedicare.com/dme/forms/advance_beneficiary_notice_of_noncoverage_forms.html

Appeals Ask the Contractor Teleconference Q&A – April 3, 2013

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

Email Listserv

If you aren't already signed up for our email updates, we strongly encourage you to do so. We send emails every Tuesday and Friday containing the latest news, updates, workshop announcements, and more. To sign-up, go to our website, and click on E-mail Newsletter Sign Up on the left-side of any page.

Endeavor

Suppliers are encouraged to register for Endeavor which offers free, online access to patient eligibility, claim status, same or similar inquiries and claim specific remittance advices. Suppliers, billers and third parties may register for Endeavor. Each person accessing Endeavor must register for their own User ID. User IDs cannot be used by more than one person.

To register, go to the claims page of our website. Many suppliers are already taking advantage of this tool and we highly encourage you all to do so as well!

Provider Enrollment, Chain and Ownership System (PECOS) Update

Noridian would like to remind suppliers of the upcoming PECOS editing. In the future, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. 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.

Questions Asked Prior to ACT

Q: Does a 5 year oxygen restart require a dispensing order?

A: It is not necessary to have a new dispensing order for oxygen Reasonable Useful Lifetime (RUL). It is up to the beneficiary to elect replacement at the end of the five year period. A new initial Certificate of Medical Necessity (CMN) is needed and proof of continued medical need would be required.

Q: Does a dispensing order for supplies used with a Continuous Positive Airway Pressure (CPAP) device need to detail which items are being ordered or can it just say CPAP and supplies and then we send a detailed written order to be signed by the physician prior to billing?

A: Yes, this would be appropriate as long as the detailed written order listed out the items.

Q: Will all dispensing orders for supplies that are associated with making the piece of equipment work need to be detailed out as well for items like suction machine or nebulizer machine?

A: Yes, all of the accessories would need to be listed.

Questions Asked During ACT

Q: When a patient is receiving a drug that is not covered and there is a proper Advanced Beneficiary Notice of Noncovereage (ABN) on file, would the 13-month pump rental and the transfer of ownership apply in those circumstances where the therapy is not being paid for?

A: The 13 month rental guidelines would still apply as the Infusion pump still meets the payment category and therefore would have to follow the payment category rules. After 13 rental months have been paid by the beneficiary, the ownership of the pump would transfer to the beneficiary.

Q: Will the denials for PECOS have appeal rights?

A: Yes.

Q: If there is no published Medically Unlikely Edit (MUE) for a code, how is it determined what would be overutilization and would cause a denial?

A: Some items have a medical necessity quantity that is allowed and are not considered an MUE. Not all MUEs are published in order to prevent over excessive dispensing of items. Suppliers should also be aware that for supplies for major components, there is only a three-month dispensing allowance. Per the policy, a three-month limitation is allowed by Centers for Medicare & Medicaid Services (CMS).

Follow-up Question:

If the MUE is not public information, how does a supplier know when to get an ABN?

A: If the supplier feels that the quantity being requested is over a reasonable or medically necessary amount, an ABN should be obtained. This would be considered on an individual basis and would vary by beneficiary. The medical record should support the need for the amount of supplies being provided.

Q: If a prescribing doctor is documenting the result of a procedure that another physician has done in the progress notes, would that signed note be an acceptable signature?

A: Yes, that would be acceptable.

Q: Is there a specific link to the form needed to appeal at the Administrative Law Judge (ALJ) level?

A: Yes, the link is http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20034ab.pdf.

Q: Is there anything being done to assist the ALJ workload get caught up?

A: The Office of Medicare Hearings and Appeals is aware of the problem. Administration is doing a variety of things to streamline the way cases are being handled.

Follow-up Question:

Is it correct to submit subsequent claims, get the denial and turn around and appeal those claims so suppliers don't have problems with timely filing?

A: Yes.

Follow-up Question:

If a supplier does not appeal every month, is it correct to wait for the decision from the ALJ and then open up the other claims so they can pay off of that CMN, for instance with an oxygen CMN?

A: No, a favorable decision at an ALJ level is not going to guarantee payment for future claims, even if it is for a CMN issue. The information that the Qualified Independent Contractor (QIC) and ALJ receive is date specific and will only allow payment for that date of service. In the example of oxygen, the date of service that is appealed is the only claim that will get paid. All subsequent claims will continue to deny as the QIC and ALJ have different standards in which they follow to allow claims. It is best to appeal all dates of service in a timely manner to avoid losing appeal rights on these claims.

Q: A doctor surgically puts in a G-tube, submits the claim and gets paid. If this G-tube shows up in all of the physician's orders for enteral feeding, would that be sufficient medical documentation for tube-feeding coverage?

A: No, the supplier would also need to establish the medical need for the enteral or G-tube feeding in general which will need to be documented and not just be a diagnosis on the claim. The Enteral Nutrition Local Coverage Determination (LCD) spells out very carefully what is all necessary.

Q: If a supplier bills for an enteral formula and receives a denial which is subsequently denied at the ALJ level as well, how do they go back and bill for another formula for that date of service if it is past the 12 month timely filing limit?

A: The criteria for specific enteral formulas are outlined in the LCD. Suppliers should evaluate each order to determine whether the coverage criteria is met for the formula prescribed. Suppliers are then required to bill for the formula provided. If the beneficiary does not meet the coverage criteria an ABN should be executed. If a supplier believes the coverage criteria to be met and yet subsequently is denied at the ALJ level, there is no ability to go back and rebill that date of service for another formula because it was not provided.

Q: If a piece of equipment gets reviewed and is denied for one supplier, can a new supplier receive information on same and similar for that item?

A: This depends on the equipment provided. Same and similar information is not available for all equipment on a pre-claim basis. Please review the same and similar reference chart located at https://www.noridianmedicare.com/dme/news/docs/2009/05_may/same_or_similar_reference_chart.html. Suppliers should ensure that they have a thorough intake process so that they are asking the beneficiary if they have received that item or service previously.

Q: Is it a possibility to have the enteral nutrition policy include more detail on what documentation is needed to support the need for the specialty formulas?

A: Suppliers have the option to go through the LCD reconsideration process if they feel a policy needs to be changed, updated or include more information.

Q: In order to establish continued medical necessity, is it sufficient for a supplier to get the detailed written order on a yearly basis and then provide updated progress notes to establish medical necessity within six months of the date of service and denial?

A: Yes.

Q: Is it correct that the ALJ and reconsideration appeal levels are both date specific, but not the reopening and redetermination level of appeal?

A: Yes, if an approval is granted at the redetermination level, the CMN, DME Information Form (DIF) or capped rental item will be updated in the system to reflect that approval for dates of service on or after that date. An ALJ and reconsideration appeal is only for the specific date that is appealed at that level.

Q: If a beneficiary has received a denial due to a physician not enrolled in PECOS, can the supplier recommend that the beneficiary find a physician who is enrolled?

A: Yes, it might be a good idea to have a conversation with that beneficiary to let them know that the only referrals we can take are from physicians enrolled in the Medicare Program. Suppliers are not allowed to refer to a specific physician, just to advise the beneficiary that they should be seeing a physician who is enrolled.

Follow-up Question:

If the noncompliant physician gets enrolled, is it a break in service or break in billing situation?

A: This would be a break in billing situation. The supplier can start billing again from the new date that the physician becomes enrolled again.

Q: Is it correct that the dispensing order and the proof of delivery cannot be on the same form?

A: If the order is detailed enough to itemize the actual HCPCS codes that are being billed for, it should be acceptable.

Q: Will the PECOS denials deny as patient responsibility?

A: Yes, Medicare cannot pay for an item that is ordered by a non-Medicare enrolled physician.

Q: The Winter 2003 Durable Medical Equipment Regional Carrier (DMERC) Dialogue included a form for oxygen testing during exercise that we have been giving physicians to document all three tests in an office setting. Now we are being told that does not qualify as medical records, yet it was published by the DMERC at the time and was not something we as suppliers created. We are receiving denials if that same information is not in the beneficiary's medical record. Why is it not being accepted?

A: Regardless who creates a form the information must be corroborated in the beneficiary's medical record.

The Program Integrity Manual, Publication 100-8, Chapter 5, section 5.7 says:

"However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient'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)."

Q: For a supplier to be able to order a power wheelchair, does it need to be documented that the physician watched the beneficiary and they were not able to push or pedal a wheelchair across the room. Would this be considered adequate documentation?

A: No, that does not need to specifically documented however the reviewer needs to be able to get an idea of the whole picture and be able to determine that a manual wheelchair would not meet the beneficiary's needs. There needs to be justification that the physician has considered each of the options outlined in the National Coverage Decision (NCD) of Mobility Assisted Equipment and that they individual has the need for a power wheelchair. The physician needs to address whether or not this beneficiary can use a manual wheelchair or a power-operated vehicle.

Q: Why can't the reason for denial rational be more specific than "we've already paid the maximum number of units allowed per month"? Can't the contractor point out where the documentation is lacking in medical necessity for the overutilization so we can go back to the doctor's office to get better chart notes?

A: Each letter is created based on the review that was completed which includes a detailed paragraph. This explanation includes the coverage criteria that were not met and/or a statement explaining what was not met in the medical documentation.

Q: Why does a supplier receive denials indicating the beneficiary has received the maximum number of units for a three month supply? If the reviewer takes the time to look up the past three months worth of orders and can see clearly that we have shipped the same number of units to the beneficiary each month, wouldn't it be clear the beneficiary does not receive quarterly orders?

A: Examiners check to make sure that the beneficiary did not receive supplies from another supplier during the last three months. If this happens, the redetermination denial would be the beneficiary has received the maximum number of units for a three month supply.

Q: When appealing a supply claim for a device/prosthetic/orthotic, does medical necessity for the device itself have to be justified as well? For example if a prosthetic patient requires replacement of prosthetic liners due to changes in the residual limb but has had liners within the past year do we have to justify the prosthesis as well as the liners if only the liners were on the claim?

A: The item that is being replaced would be the item being reviewed. The medical necessity for the prostheses would not be reviewed as it has already been deemed to be a medical necessity.

Q: Are there any checklists available for audit details? We have the documentation checklists but it does not state specific things that they look for like whether a doctor has signed each visit and I have not seen this in any policy. Therefore we have to go to the next level of appeal for insufficient documentation because we were unaware of this criterion.

A: There is no checklist for the reviews. But in this case there was an MLN (MM6698) on signature requirements that we follow. It states that documentation must be authenticated by the author.

DME on Demand – Respiratory Suction Pumps

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

This session will include:

- Acronyms and Definitions
- Coverage
- Modifiers
- Documentation
- Resources

Viewing Presentation

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

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

DME on Demand – Speech Generating Devices (SGD): Speech Language Pathologist (SLP) Evaluation

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

This session will include:

- Acronyms and Definitions
- SLP Evaluation Criteria
- Resources

Viewing Presentation

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

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

DME on Demand – Tracheostomy Care or Cleaning Starter Kits

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

This session will include:

- Acronyms and Definitions
- Types of Kits
- Billing
- Resources

Viewing Presentation

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

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

General Ask the Contractor Teleconference Q&A – March 14, 2013

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

Email Listserv

If you aren't already signed up for our email updates, we strongly encourage you to do so. We send emails every Tuesday and Friday containing the latest news, updates, workshop announcements, and more. To sign-up, go to our website, and click on E-mail Newsletter Sign Up on the left-side of any page.

Endeavor

Suppliers are encouraged to register for Endeavor which offers free, online access to patient eligibility, claim status, same or similar inquiries and claim specific remittance advices. Suppliers, billers and third parties may register for Endeavor. Each person accessing Endeavor must register for their own User ID. User IDs cannot be used by more than one person. To register, go to the claims page of our website. Many suppliers are already taking advantage of this tool and we highly encourage you all to do so as well!

Educational Opportunities

Noridian has some exciting new education opportunities for suppliers! First, we have started offering a new format for the all day In-Person Seminars which are titled "Documentation & Dialogue". This new format consists of a general documentation presentation in the morning. This presentation has been approved for 1 CEU credit. This is followed by an afternoon session which consists of breakout sessions for suppliers to ask questions directly to our Education staff regarding the topic for that table. Topics that will be covered are posted in the article that is published to our website.

We also have a new self-paced learning tool titled "DME on Demand". This is a pre-recorded online presentation that enables suppliers to watch and listen at their convenience. These are posted out on our Educational Tools portion of the webpage. Keep watching our website for more of these to be added in the coming months.

Survey

Our customer satisfaction is very important to us here at Noridian. We strongly encourage all suppliers to take the ForeSee Survey that pops up for you to let us know how we are doing. This survey is a supplier's opportunity to give us feedback on our website to ensure that you are getting the best experience every time you visit. We welcome any and all comments!

Questions Asked Prior to ACT

Q: Please provide more information on how a reviewer determines whether or not to pay a claim based on there not being documentation that the beneficiary supply has been exhausted.

A: The refill requirements are well defined in the standard documentation language. A need by date or previous refill date would not be evidence enough for a refill need as specified in the language.

Per the IOM, Chapter 5, Section 5.2.5–6:

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-consumables (e.g. CPAP supplies) – Functional condition of the item being refilled to demonstrate the cause of the dysfunction that necessitates replacement*

Q: Is there anything a supplier can do to stop repeat requests for the same beneficiary?

A: The claims processing system randomly pulls the claims based on specific logic. At this time, the suppliers will need to continue to send in the documentation requested.

Q: A beneficiary is on antibiotics on an external infusion pump. The detailed written order (DWO) has a start date of 2/11/13 but the antibiotics have to be shipped on 2/7/13 in order for the beneficiary to be able to start therapy on 2/11/13. What is the start date of the DME Information Form (DIF), 2/11/13 per the DWO or 2/7/13 for the first ship date?

A: An antibiotic going through an external infusion pump must have an ABN (GA) modifier if want a PR denial is desired to send to secondary. But the DIF initial date can be either the date the physician gives as a start date or the date of the order.

Per the PIM: 5.3.1 – Completing a CMN or DIF

(Rev. 281, Issued: 281, Effective: 02-02-09, Implementation: 02-02-09)

The "Initial Date" found in Section A of the CMN, should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the "Initial Date" would be the date of the order.

Q: If a supplier does not document the home safety assessment prior to setup of the manual wheelchair, can the documentation of the home safety evaluation be obtained after the fact or does this make the beneficiary not qualify for the manual wheelchair?

A: An assessment must take place before or during the time of delivery. From the LCD: 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.

Q: When a beneficiary does not qualify for a piece of DME, a medical necessity denial is received and the beneficiary will need to be re-qualified, does the supplier need a new dispensing order if the previous is less than 90 days old? Does there need to be a new evaluation for the equipment or can the previous be used? (This pertains to DMEPOS items and not oxygen)

A: If the order was written before new documentation was created, then a new order would need to be obtained. If the previous evaluation was not sufficient, then a new evaluation would need to be obtained.

Q: Can the fax cover sheet from a hospital or skilled facility that shows the beneficiary's anticipated discharge date be used to validate why the item may be delivered prior to discharge?

A: A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's anticipated discharge to their home. Documentation submitted should either clearly indicate the discharge date and that it was within two days of when the item was delivered or documentation showing what the 'anticipated discharge date' was to verify it was within two days.

Questions Asked During ACT

Q: When billing Medicare for denial, if it is a noncovered service or a service that the patient does not meet criteria, does a DME Information Form (DIF) still need to be completed?

A: A DIF needs to be completed and sent in with the claim, even if it is a non-qualifying DIF.

Q: If a supplier ships out supplies to a beneficiary and the beneficiary dies before the supply is exhausted, is the supplier subject to recoupment in this situation?

A: If the order and supply needed was correct at the time of shipment, the supplier is not subject to recoupment if something happens that the supply is not all used.

Q: If a beneficiary is coming into the store and receiving items, is there any need to have proof of exhaustion?

A: No, in this situation there is no need for proof of exhaustion. An article titled "Items Provided on a Recurring Basis" states: For items that the patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

Q: If a supplier is going to the nursing home to dispense nutrition supplies, does the supplier need to show inventory for proof of exhaustions of formula before each weekly or biweekly delivery?

A: Yes, prior to a delivery being made, suppliers will need to check to make sure that the beneficiary receiving the delivery has nearly exhausted supplies and document how much is left. This is required whether it is for a weekly, biweekly or monthly delivery, the rules apply to all circumstances.

Q: If it is the first time an item is being prescribed to a beneficiary, there does not need to be documentation showing the supply was exhausted or refill request, correct?

A: Correct, if it is the very first time if the beneficiary is receiving that item. If it is only the first time this specific supplier is providing the item and the beneficiary had previously been given the item(s) by another supplier, then the refill requirements would still apply.

Q: How does a new supplier know if the order being provided is new to the beneficiary or if they had received this previously from another supplier?

A: Suppliers should have a thorough and aggressive intake process. It is important to be asking the beneficiary as well as the physician that is ordering the supply, whether the beneficiary has received the item/service before, how many years or days have they been utilizing the item/service and when the most recent physician visit occurred..

Q: There is an initial DIF for B4150 formula, then the orders are changed to B4154 formula with a new DIF being completed. The orders are then changed back to B4150 formula. Which DIF needs to be revised?

A: The initial DIF for the B4150 formula would still be open and available in the instance that a physician

decides to go back to the regular formula.

Q: Regarding LCD L11581 for urological supplies. Under indwelling catheters (for more than one catheter per month), the criteria states must have history of recurrent obstruction or urinary tract infection, for which it has been established that an acute event is prevented by a scheduled change frequency of more than one per month. Do you have to show that the additional catheters have prevented the recurrent UTI or obstruction? Or is the fact that they already had a history of recurrent UTI or obstruction, sufficient to justify the additional catheters?

A: For an indwelling catheter, it's not the intent to retrospectively show that something was successful. A reason for using more than one catheter in the approved frequency of change period would need to be documented in the record. In review of long term utilization, a question might be raised if only recurrent UTI were used to justify over-utilization, possibly misusing the intent. But, for regular purposes of the policy, the intent is to be able to provide the additional catheters to alleviate? infections which are more intense in nature or more frequent infections.

Q: Please provide direction on where information can be found on handling a new order in regards to the thorough intake process. Is there anything that can be provided to a pharmacist to explain what is needed?

A: This is something that is relayed during all of our presentations. Noridian strongly encourages suppliers to have an aggressive intake process. There is a form on our website that can be used as well. This suggested intake form [PDF] is listed on our website under the Forms tab, titled Suggested Intake Form. This form is a suggestion and not a requirement; however suppliers are encouraged to take advantage of it. Suppliers can also use the Dear Physician letters that have been created to indicate that documentation is going to be needed in order to pass any reviews. It is crucial for suppliers to ask the right questions and ensure a process is in place to determine that all documentation is being obtained.

Q: THE NSC website talks about inexpensive and routinely purchased items and the fact that suppliers need to obtain an IRP form. Is this something that supplier are held to under Supplier Standard #5?

A: The standard requires suppliers only to advise beneficiaries that they may purchase or rent the equipment or durable accessory items, not the supplies. Since Medicare does not rent disposables, the standard #5 does not apply to these items.

Q: When a doctor orders oxygen, does the dispensing order need to be specific in regards to items such as liquid vs. gas and portable vs. stationary?

A: The detailed written order which is received prior to billing Medicare needs to be very specific. Contractors need to be able to verify that the HCPCS code that is being billed is what is on the order. Suppliers must provide the modality ordered by the physician. .

Q: What is an email address that suppliers can use for sending in general questions?

A: The email address is dme@noridian.com. This is located on our website under the "E-mail us" option. Please ensure that there is no Protected Health Information (PHI) included in any emails sent.

Q: Can a physician write the justification for the need of oxygen on the order page or does that have to be documented somewhere in the chart notes?

A: There needs to be medical justification within the medical records for items ordered. Orders or prescriptions are not medical records.

Q: For Enteral patients with partial functional impairments, how does a supplier determine at what point the patient does not qualify?

A: The patient must require tube feedings to maintain weight and strength commensurate with the patient's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

Q: Regarding enteral beneficiaries that have a malabsorption problem, is a diagnosis for something causing the malabsorption i.e. pancreatic cancer enough or does the diagnosis for malabsorption or malnutrition need to be included as well?

A: Where the clinical situation is clear, it meets the criteria in the policy. The diagnosis for pancreatic cancer

should be sufficient without a specific malabsorption diagnosis. Criteria needs to be met according to policy.

Q: If a delivery was made according to the order on file, but when inventory was obtained for the next delivery, there was a new order to decrease supplies. What happens to the supplies that had already been dispensed to the beneficiary?

A: The supplier will need to reevaluate the next shipment of supplies. The shipment would include what is needed taking in to account what the new order entails and how much the beneficiary has left from the last shipment.

Q: What should a supplier do if a new patient was previously being given supplies by another supplier who is choosing not to share information that was on the DME Information Form (DIF) or the treating physician does not have the information on record? Would this be a situation for an Advanced Beneficiary Notice of Noncovereage (ABN)?

A: A physician should be following that patient going forward and they should have the ability and authority to fill out the needed documentation going forward. Suppliers should be able to go to the person managing that care and explain they are the new supplier for that beneficiary and explain the information that is needed.

Q: If a supplier is unable to get the initial date on the DIF that a previous supplier had submitted, would an ABN be applicable?

A: Suppliers are able to look up DIF information on the Interactive Voice Response system (IVR) and Endeavor. The Office Inspector General (OIG) has become more strict with suppliers not being able to receive documents vs. the supplier not wanting to make the effort and take appropriate steps to get the information needed. If the supplier is truly not able to receive the information needed, an ABN would be applicable but this should be very unusual.

Q: According to the Dear Physician letter for oxygen, there are six requirements. Some of these apply to an initial CMN and some apply to a recert Certificate of Medical Necessity (CMN). For number six, the method of delivery is needed. For a restart CMN, is that information required to be in the chart notes? Physicians often forget this information.

A: Medical records for the initiation of therapy should establish the mode of delivery. Because a Detailed Written Order does require the mode of delivery both Initial and Recertification CMNs should list that method if they are being utilized as the DWO. Due to continuation of service it would not be necessary for the medical records to reflect specifically that the mode of delivery had not changed as long as there was documentation that the need for oxygen was unchanged.

Q: What should a supplier do in the situation that a delivery was made to a facility for a beneficiary and the need was then discontinued and the leftover suppliers were picked up?

A: The items do not need to be picked up. The supplies were dispensed in good faith that they were needed at the time. These items can be billed for by the supplier as it was accurate at the time it was dispensed. The supplies are then the property of the beneficiary.

Q: Does the report for the sleep study done on a CPAP have to be authenticated?

A: Yes, it should be authenticated by the person who performed the test.

Q: In the event of an audit, what support in writing can a supplier use to note that information in regards to method of delivery, frequency and liter flow for the restart of a CMN is not required?

A: Documentation does not need to respecify these items. If the original order shows what was being used, the recertification does not need to cover those items as well. If the items being used were not on

the initial CMN, that is different and it would need to be documented and specified on the recertification CMN.

Q: A beneficiary has private insurance and delivery of enteral nutrition was made on the 15th of March. The supplier was then notified that the beneficiary would be Medicare eligible as of April 1st. Would the DIF date be the delivery date of March 15th or the day Medicare eligibility began on April 1st?

A: The billing date would need to be the delivery date, which is March 15th. Medicare would not cover the suppliers dispensed on March 15th because the beneficiary was not enrolled in Medicare. When the next delivery goes out, if it is after the Medicare eligibility date of April 1st, the supplier would then be able to bill Medicare with the delivery or if shipped the ship date.

The DIF date would be the Medicare eligibility date.

Q: Does enteral nutrition require a date span?

A: Yes, billing for enteral nutrition does require a date span.

Q: If a supplier has a change in physician or therapist, how would that be reflected on a current DIF?

A: A revised DIF can be done for that suppliers records, this will ensure that the suppliers records are current, clear and concise.

Q: If an enteral nutrition patient has a chronic neurological condition such as dementia/Parkinson's/ Alzheimer's, if the patient has had a speech therapy evaluation that states they passed/no dysphagia, but they are still unable to meet needs through oral nutrition, and the tube feeding is supplying the majority of the patient's needs, would we still be able to qualify the patient?

A: In order for the beneficiary to meet the Prosthetic Device benefit of the Social Security Act for enteral nutrition, the beneficiary needs to either have a permanent non-function or disease of the structures that normally permit food to reach the small bowel OR disease of the small bowel which impairs digestion and absorption of an oral diet. Either of these conditions would require tube feedings to provide sufficient nutrients to maintain weight and strength.

Q: Does the ordering doctor need to sign off on the qualifying saturation testing done by hospital personnel for a hospital discharge with oxygen?

A: In order to authenticate the record, the author of the qualifying testing documentation would need to sign. Subsequently, it would be expected that the ordering physician would sign the entire record certifying the order.

Q: On a hospital oxygen discharge, does the ordering physician need to reference the qualifying saturation test percent in the written order?

A: It is not a requirement that the qualifying saturation test percentage be listed on the dispensing order. Please see Chapter Three in the Noridian Supplier Manual for detailed information on the Standard Documentation requirements for dispensing orders.

Q: If a sleep study determines the patient does not have OSA, can it be used to qualify the patient for oxygen or must they have a separate test for oxygen?

A: As noted in the oxygen LCD, a beneficiary must be in a chronic stable state in order to qualify for home oxygen therapy. If the medical records establish that this is the case and the remaining criteria of the policy are met, oximetry testing done by any qualifying testing entity would be valid.

Q: If the patient has OSA and has tried a CPAP but cannot tolerate it, can they ever get oxygen covered by Medicare? What documentation would be needed?

A: If a beneficiary has untreated OSA, they would not be considered to be in a chronic stable state and therefore would not meet the coverage criteria as clarified in the oxygen LCD. It would be incumbent on their physician to work with the beneficiary for proper diagnosis and treatment of their condition.

First Quarter 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 codes B4154. The first quarter edit effectiveness results from December 2012 through March 2013 are as follows:

The B4154 review involved 368 claims of which 318 were denied. This resulted in an overall error rate of 86%.

Primary Documentation Errors that Resulted in Denial of Claims

26% of B4154 claims received a denial as no/invalid beneficiary exhaustion was provided.

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.

13% 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.

8% of B4154 claims received a denial as the physician order is incomplete or is 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.

8% of B4154 claims received a denial as the proof of delivery is 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 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 on the Noridian website at https://www.noridianmedicare.com/dme/coverage/resources/enteral_nutrition.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian provides educational offerings by scheduling 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

Results of Widespread Prepayment Probe Review of Enteral Nutrition (HCPCS B9002)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS code B9002. This review was initiated due to the results of Comprehensive Error Rate Testing (CERT) analysis.

The B9002 review involved 282 claims of which 229 were denied. This resulted in an overall error rate of 88%.

Primary Documentation Errors that Resulted in Denial of Claims

19% of B9002 claims received a denial due to not receiving documentation 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.

8% of B9002 claims received a denial as proof of delivery documentation for the items billed was not submitted.

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.

8% of B9002 claims received a denial as no proof of delivery was submitted.

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

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

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

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

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

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

7% of B9002 claims received a denial as the date of the physician's signature was after the date of service and no verbal or dispensing order was provided.

Dispensing Orders

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

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

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

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

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

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

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

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

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

The DWO must be available upon request.

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

If a supplier does not have a faxed, photocopied, electronic or pen and ink signed order in their records before they submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. If the claim is for an item for which an order is required by statute (e.g., therapeutic shoes for diabetics, oral anticancer drugs, oral antiemetic drugs which are a replacement for intravenous antiemetic drugs), the claim will be denied as not meeting the benefit category and is therefore not appealable by the supplier (see CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, for more information on appeals). For all other items, if the supplier does not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary, with the exception of items requiring a written order prior to delivery as indicated below.

Reminders

If an order is taken verbally and sent to the physician for a signature and date, there are two documents: the verbal order and the written order with the physician's signature and date.

If a patient comes in with a prescription containing all of the elements of a detailed written order, then one document is on file.

It's important to remember that if an item is dispensed based on a verbal order and a written order is provided afterwards, both orders must be retained. It is not adequate to only have a written order after dispensing an item. There must be documentation to show the verbal order was received prior to dispensing the item.

Going Forward

Noridian will close this probe 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 at https://www.noridianmedicare.com/dme/coverage/resources/enteral_nutrition.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian provides educational offerings by scheduling 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

Third Quarter Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4035)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes B4035. The third quarter edit effectiveness results from January 2013 through April 2013 are as follows:

The B4035 review involved 1,133 claims of which 964 were denied. This resulted in an overall error rate of 86%.

Historical Data of the Error Rate for B4035 Review

Primary Documentation Errors that Resulted in Denial of Claims

26% of B4035 claims received a denial as no/invalid beneficiary exhaustion was provided.

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.

14% of B4035 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.

9% of B4035 claims received a denial as invalid Proof of Delivery or no Proof of delivery submitted.

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

6% of B4035 claims received a denial as the physician order submitted has incomplete or missing elements.

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

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

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

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

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

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

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

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

The dispensing order must be available upon request.

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

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 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 at https://www.noridianmedicare.com/dme/coverage/resources/enteral_nutrition.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian provides educational offerings by scheduling 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

Coverage Reminder – Requirements for High Utilization of Glucose Monitor Strips and Lancets

Medicare receives numerous claims for home blood glucose monitor strips and lancets. Many of these claims are for a higher than usual numbers of supplies. The Glucose Monitors local coverage determination has special coverage requirements for glucose supplies at all levels of utilization. The general coverage requirements in the policy state:

To be eligible for coverage of home blood glucose monitors and related accessories and supplies, the beneficiary must meet both of the following basic criteria (1) – (2):

- The beneficiary has diabetes (ICD-9 codes 249.00–250.93); and
- The beneficiary's physician has concluded that the beneficiary (or the beneficiary's caregiver) has sufficient training using the particular device prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing.

The specific policy requirements for supplies state:

The quantity of test strips (A4253) and lancets (A4259) that are covered depends on the usual medical needs of the beneficiary and whether or not the beneficiary is being treated with insulin, regardless of their diagnostic classification as having Type 1 or Type 2 diabetes mellitus. Coverage of testing supplies is based on the following guidelines:

Usual Utilization

- For a beneficiary who is not currently being treated with insulin injections, up to 100 test strips and up to100 lancets every 3 months are covered if the basic coverage criteria (1) – (2) (above) are met.
- For a beneficiary who is currently being treated with insulin injections, up to 300 test strips and up to 300 lancets every 3 months are covered if basic coverage criteria (1) – (2) (above) are met.

High Utilization

- For a beneficiary who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a) – (c) below are met.
- For a beneficiary who is currently being treated with insulin injections, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a) – (c) below are met.
- Basic coverage criteria (1) – (2) listed above for all home glucose monitors and related accessories and supplies are met; and,
- 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; and,
- 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.

If neither basic coverage criterion (1) nor (2) are met, all testing supplies will be denied as not reasonable and necessary. If quantities of test strips or lancets that exceed the utilization guidelines are provided and criteria (a) – (c) are not met, the amount in excess will be denied as not reasonable and necessary.

DMEPOS suppliers who provide glucose supplies are reminded that the requirements set out in the local coverage determination must be supported by information from the medical record. While suppliers are not required to obtain this information in advance of claim submission, in the event of an audit this information must be available upon request.

The information in the medical record must document the diagnosis of diabetes, the nature of treatment (non-insulin treated or insulin treated), the quantity of supplies, as well as the special requirements outlined above.

Suppliers are reminded that in addition to the medical record information required, a prescription (detailed written order), refill monitoring and proof of delivery documentation are required.

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

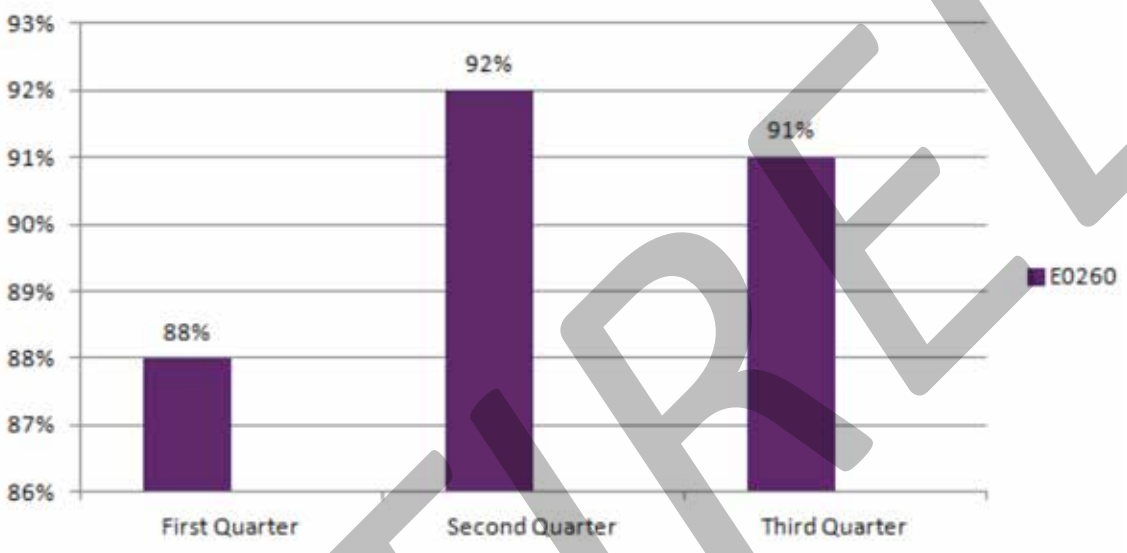
Third Quarter Results of Widespread Prepayment Review of Claims for Hospital Beds (HCPCS E0260)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0260. The third quarter edit effectiveness results from October 2012 through January 2013 are as follows:

The E0260 review involved 6,424 claims of which 5,761 were denied. This resulted in an overall error rate of 91%.

Historical Data of the Error Rate for E0260 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 30% of E0260 claims received a denial as Criteria for fixed height not met.
- 27% of E0260 claims received a denial as Criteria for semi-electric bed not met.

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

1. The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, or
4. 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.

- 8% of E0260 claims received a denial as no office notes/medical records 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 file by the supplier, and be available upon request.

- 4% of E0260 claims received a denial as POD prior to DOS.

Per Supplier's Manual Chapter 3, Suppliers may deliver the item 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)
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The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility. A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and use the place of service (POS) as 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Going Forward

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

Education Resources

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

Noridian Administrative Services' 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.

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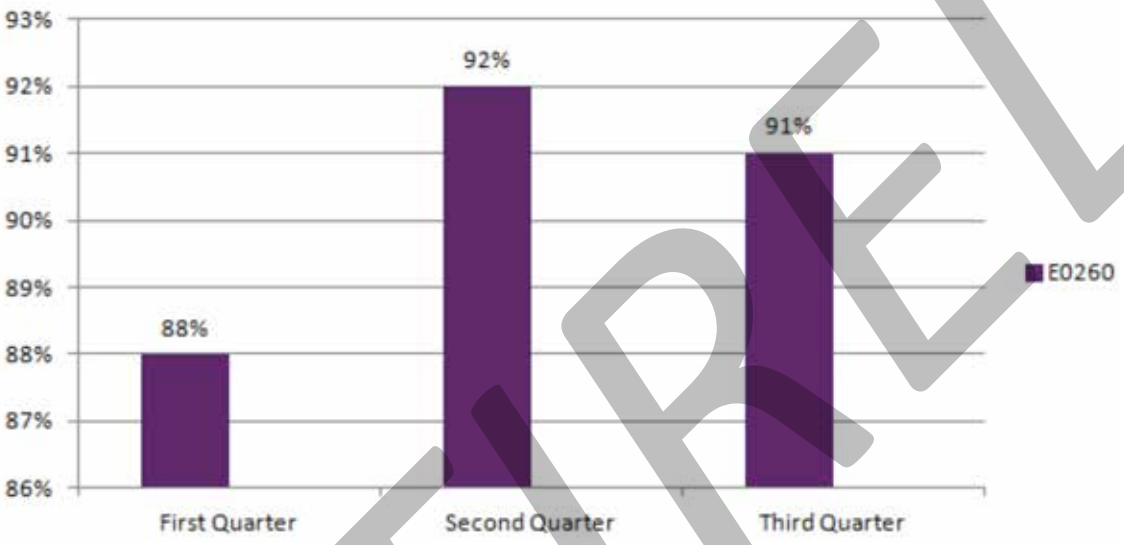

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ICD-10 CM – Updates to National Coverage Determination/Local Coverage Determination Processing in VMS Shared System

MLN Matters® Number: MM8207
Related Change Request (CR) #: CR 8207
Related CR Release Date: February 15, 2013
Related CR Transmittal #: R11910TN
Effective Date: July 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8207 which informs Medicare contractors about the details of the system changes required to accommodate separate National Coverage Determination/Local Coverage Determination (NCD/LCD) codes for policies associated with ICD-9 and ICD-10 diagnosis codes.

Background

The Centers for Medicare & Medicaid Services (CMS) is making modifications to its claims processing systems to report the appropriate NCD/LCD captured during claims processing based on their associations with either ICD-9 or ICD-10 diagnosis codes, the claim line service date and the ICD-10 on the CMS website.

Additional Information

The official instruction, CR8207 issued to your DME/MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1191OTN.pdf on the CMS website.

ICD-10 Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as They Relate to CMS NCDs

MLN Matters® Number: MM8197 Revised
Related Change Request (CR) #: CR 8197
Related CR Release Date: March15, 2013
Related CR Transmittal #: R1199OTN
Effective Date: Please note that the implementation date is prior to the effective date in order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes on October 1, 2014. The shared systems began implementation of the necessary changes to the NCDs in the January 2013 systems release with CR7818, followed by CR8109 in the April 2013 release, and finishing up with this CR split between the July 2013 and October 2013 releases (analysis and design/implementation).
Implementation Date: July 1, 2013

Note: This article was revised on March 26, 2013, to add further information on accessing the spreadsheets attached to CR8197. 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), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors, (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8197, from which this article is taken, creates and updates National Coverage Determination (NCD) hard-coded shared system edits that contain International Classification of Diseases (ICD)-9 diagnosis codes with the comparable ICD-10 diagnosis codes, along with all related coding infrastructure such as procedure codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, messages, frequency edits, Place of Service/Type of Bill (POS/TOB), provider specialties, etc.

The requirements it describes reflect the operational changes that are necessary to implement the conversion of the Medicare shared system coding from ICD-9 to ICD-10 specific to 30 NCDs that are attachments to CR8197.

In order to be prepared to meet the timeline to implement the new ICD-10 diagnosis codes on October 1, 2014, the shared systems began implementation of the necessary changes to the NCDs in the January 2013, quarterly release with CR7818, followed by CR8109 in the April 2013, quarterly release and culminates with this CR split between the July 2013, and October 2013, quarterly releases.

See the Background and Additional Information Sections of this article for further details regarding these changes, and be sure that you are ready for ICD-10 implementation by October 1, 2014.

Background

As announced in CMS-40-F, 45 CFR Part 162 [CMS–0040–F] RIN 0938–AQ13, "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements, and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets" (September 5, 2012), effective October 1, 2014, all Medicare claims submissions will convert from the 9th Edition (ICD-9) to the 10th Edition (ICD-10).

(You can find this document at http://www.gpo.gov/fdsys/pkg/FR-2012-09-05%20on%20pages%2054663-54720 on pages 54663-54720.)

All Health Insurance Portability and Accountability Act (HIPAA)-covered entities must adhere to the conversion, which will require business and systems changes throughout the health care industry. In accordance, per the ICD-10 Final Rule, published in the January 16, 2009, Federal Register, (see http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-740.pdf). The Secretary of the Department of Health and Human Services adopts the ICD-10-CM and ICD-10-PCS code sets for use in appropriate HIPAA standard transactions (including those submitted in both electronic and paper formats) **effective October 1, 2014**.

General Information Found in Spreadsheets in the Attachments

Thirty spreadsheets are attached to CR8197 indicating certain affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD. To access the attachments, go to the downloads section at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1199OTN.html on the CMS website.

Each spreadsheet contains the following information:

- NCD Number/Title;
- Internet-Only Manual (IOM) searchable link related to the NCD; and
- Medicare Coverage Database (MCD) searchable link related to the NCD.

Within each spreadsheet, there are three tabs:

- ICD Diagnosis;
- ICD; and,
- Rule Description.

Spreadsheets attached to CR8197 explain the following NCDs:

20.4 Implantable Automatic Defibrillator

20.7 Percutaneous Transluminal Angioplasty

20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance

20.30 Microvolt T-Wave Alternans

20.31 Intensive Cardiac Rehabilitation Programs

20.31.1 The Pritikin Program

20.31.2 Ornish Program for Reversing Heart Disease

40.1 Diabetes Outpatient Self-Management Training

40.7 Outpatient Intravenous Insulin Treatment

50.3 Cochlear Implantation

100.14 Surgery for Diabetes

110.4 Extracorporeal Photopheresis

110.8.1 Stem Cell Transplantation

150.10 Lumbar Artificial Disc Replacement

180.1 Medical Nutrition Therapy

190.1 Histocompatibility Testing

190.3 Cytogenetic Studies

190.5 Sweat Test

190.8 Lymphocyte Mitogen Response Assays

190.11 Home Prothrombin Time/International Normalized Ratio Monitoring for Anticoagulation Management

210.2 Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer

210.4 Smoking and Tobacco-Use Cessation Counseling

210.4.1 Counseling to Prevent Tobacco Use

210.7 Screening for the Human Immunodeficiency Virus Infection

210.10 Screening for Sexually Transmitted Infections and High-Intensity Behavioral Counseling to Prevent STIs

220.4 Mammograms

220.6.16 FDG PET for Infection and Inflammation

220.6.19 Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer

260.1 Adult Liver Transplantation

260.9 Heart Transplants

Should your contractor deny claims associated with the NCDs addressed by CR8197, they will use:

- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice of Noncoverage (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- Claim Adjustment Reason Code (CARC) 50: These services are non-covered services because this is not deemed a "medical necessity" by the payer; and

Additionally, where appropriate and not specifically indicated in the various attached spreadsheets, they will use:

- Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website.

Additionally, NCD 190.11 includes a change to CR6313 dated 1/8/09, and is also a change to the spreadsheet attached to CR8109/TR1162.

Likewise, NCD 110.4 includes a change to CR7806/TR2551 correction dated 9/24/12 that removed 996.88 from CR7806 dated 8/3/12, and a change to the spreadsheet attached to CR7818 dated 9/14/12.

Additional Information

The official instruction, CR8197 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1199OTN.pdf on the CMS website.

You will find spreadsheets that contain all affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD as attachments to this CR. To access those spreadsheets, visit the downloads section at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1199OTN.html on the CMS website.

Medicare FFS Claims Processing Guidance for Implementing ICD-10

MLN Matters® Number: MM7492 Revised
Related Change Request (CR) #: 7492
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R950OTN
Effective Date: October 1, 2013
Implementation Date: January 1, 2012

Note This article was revised on March 21, 2013, to add a reference to article SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged.

Provider Types Affected

This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (MACs), Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key Points of CR7492

- **General Reporting of ICD-10**

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

- **General Claims Submissions Information**

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

- **Claims that Span the ICD-10 Implementation Date**

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
13X	Outpatient Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE – RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
34X	Home Health – (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
71X	Rural Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76X	Community Mental Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
81X	Hospice- Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82X	Hospice – Non hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B – Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional Claim

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	FROM

Table D –Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	FROM

Additional Information

The official instruction, CR7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R950OTN.pdf on the CMS website.

See article MM7818, available at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM7818.pdf, for information on the creation and updating of hard-coded Medicare shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes and the operational changes needed to implement the conversion.

For current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website.

LCD AND POLICY ARTICLE REVISIONS

LCD and Policy Article Revisions

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.

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.

Date	Policy	Revisions
February 21, 2013	Automatic External Defibrillators	LCD Revision Effective Date: 01/01/2011 (February 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)

Date	Policy	Revisions
February 21, 2013	External Infusion Pumps	LCD Revision Effective Date: 07/22/2011 (February 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Added: J1569 to Subcutaneous immune globulin section Added: Refill requirements (Standard language) (Effective 08/04/2011) HCPCS CODES AND MODIFIERS: Added: J1569 ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: Added: J1569 DOCUMENTATION REQUIREMENTS: Added: J1569 to JB modifier requirement Added: Standard language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Clarification for use of a revised DIF when a change in drug or HCPCS occurs Policy Article Revision Effective date: 01/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble Added: DME benefit category statement Added: Drugs as a supply only benefit statement
February 21, 2013	Facial Prostheses	LCD Revision Effective Date: 01/01/2010 (February 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES: Added: Benefit Category Standard Language Changed: Word "Patient" to "Beneficiary"

Date	Policy	Revisions
February 28, 2013	Canes and Crutches	LCD Revision Effective Date: 02/04/2011 (February 2013 publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Standard Language CODING GUIDELINES: Added: Coding definition for codes E0117 and E0118
February 28, 2013	Commodes	LCD Revision Effective Date: 02/04/2011 (February 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES: Added: Benefit Category Standard Language
February 28, 2013	Eye Prosthesis	LCD Revision History Effective Date: 07/01/2007 (February 2013 publication) INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES: Added: Standard Language

Date	Policy	Revisions
February 28, 2013	Immunosuppressive Drugs	LCD Revision Effective Date: 01/01/2013 INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY: Revised: Language for clarification and addition of CMS IOM references HCPCS CODES AND MODIFIERS: Added: J0485 Changed: J8561 to J7527 for Everolimus, oral, 0.25mg DOCUMENTATION REQUIREMENTS: Revised: KX and GY Modifiers language for clarification and addition of CMS IOM references Policy Article Revision Effective Date: 1/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Language for clarification and addition of CMS IOM reference
February 28, 2013	Walkers	LCD Revision Effective Date: 02/04/2011 (February 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Replaced reference to "patient" with "beneficiary" HCPCS CODES AND MODIFIERS: Added: GY modifier DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Revised: Prescription requirements Added: General medical record information requirements, continued use and continued need requirements, and proof of delivery requirements Added: GY modifier instruction Revised: Updated HCPCS range reference with modifier usage Policy Article Revision Effective Date: 12/01/2009 (February 2013 Publication) NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES Added: Preamble and SSA reference Added: Benefit category statement CODING GUIDELINES: Added: Rollator verbiage and PDAC verification

Date	Policy	Revisions
March 7, 2013	Cervical Traction Devices	LCD Revision Effective Date: 02/04/2011 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirements language to specify a "detailed written order" Changed: Word "patient" to "beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Policy Article Revision Effective Date: 04/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble Added: DME benefit category statement
March 7, 2013	Infrared Heating Pad Systems	LCD Revision Effective Date: 07/01/2007 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Language clarifying NCD 270.6 as the reason for denial Changed: Word "patient" to "beneficiary" Policy Article Revision Effective Date: 04/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble Added: DME benefit category statement
March 7, 2013	Lower Limb Prostheses	LCD Revision Effective Date: 01/01/2013 INDICATIONS AND LIMITATIONS OF COVERAGE: Added: L5859 coverage criteria HCPCS CODES AND MODIFIERS: Added: L5859 DOCUMENTATION REQUIREMENTS: Added: L5859 to policy specific section Policy Article Revision Effective Date: 01/01/2013 CODING GUIDELINES: Added: Preamble Changed: Word "Patient" to "Beneficiary"

Date	Policy	Revisions
March 7, 2013	Manual Wheelchair Bases	LCD Revision Effective Date: 03/01/2013 (March Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Coverage criteria for K0005 and E1161 to conform with DMEPOS Quality Standards as a complex rehabilitation product DOCUMENTATION REQUIREMENTS: Revised: Proof of delivery section Policy Article Revision Effective Date: 03/01/2013 CODING GUIDELINES: Revised: Weight clarification for coding Revised: Degree of tilt requirement for E1161 and guidance for coding if less than 20 degrees of tilt
March 7, 2013	Wheelchair Options/ Accessories	LCD Revision Effective Date: 01/01/2013 HCPCS CODES AND MODIFIERS: Added: E2378 DOCUMENTATION REQUIREMENTS: Revised: Proof of delivery POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Changed: Narrative for same claim billing requirement of accessories and base Policy Article Revision Effective Dated: 01/01/2013 CODING GUIDELINES: Added: Lap belt/safety belt to POV basic equipment package Added: Guidelines for use of K0108 for heavy duty/bariatric Added: Requirements regarding degrees of tilt and no separate payment if not meeting tilt requirement Added: E2378 to bundling table
March 14, 2013	Osteogenesis Stimulators	LCD Revision Effective Date: 08/01/2009 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" Added: Refill requirements DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Revised: Prescription requirements Policy Article Revision Effective Date: 08/01/2009 (March 2013 Publication) NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement

Date	Policy	Revisions
March 14, 2013	Patient Lifts	LCD Revision Effective Date: 02/04/2011 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Revised: Prescription requirements Policy Article Revision Effective Date: 01/01/2010 (March 2013 Publication) NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement Changed: "Patient" to "Beneficiary"
March 14, 2013	Pressure Reducing Support Surfaces – Group 2	LCD Revision Effective Date: 01/01/2011 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Language explaining coverage criteria Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard language (Note: The effective date above is not applicable to these items. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Removed: Requirement for the Statement of Certifying Physician (effective April 1, 2013) Policy Article Revision Effective Date: 04/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Changed: "Patient" to "Beneficiary" CODING GUIDELINES: Added: Statement for heavy duty and bariatric devices

Date	Policy	Revisions
March 14, 2013	Seat Lift Mechanisms	LCD Revision Effective Date: 02/04/2011 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirement language to specify a "written order prior to delivery" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Revised: Prescription requirements Policy Article Revision Effective date: 09/01/2009 (March 2013 Publication) NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement Changed: "Patient" to "Beneficiary"
March 14, 2013	Urological Supplies	LCD Revision Effective Date: 02/04/2011 (March 2013 Publication) INDICATIONS AND LIMITATIONS OF COVERAGE: Revised: Order requirement language to specify a "detailed written order" Added: Refill requirements Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: Added: Standard Language (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Revised: Prescription requirements Policy Article Revision Effective Date: 02/04/2011 (March 2013 Publication) NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Benefit category statement Changed: Word "Patient" to "Beneficiary"

Date	Policy	Revisions
March 21, 2013	Hospital Beds and Accessories	LCD Revision Effective Date: 02/04/2011 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Policy Article Revision Effective Date: 04/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES Added: Preamble and benefit category statement CODING GUIDELINES: Changed: Word "Patient" to "Beneficiary"
March 21, 2013	Nebulizers	LCD Revision Effective Date: 08/02/2011 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES: Changed: Word "Patient" to "Beneficiary"
March 21, 2013	Ostomy Supplies	LCD Revision Effective Date: 01/01/2013 HCPCS CODES AND MODIFIERS: Added: A4435 Policy Article Revision Effective Date: 01/01/2013 CODING GUIDELINES: Added: A4435 Changed: Word "Patient" to "Beneficiary"

Date	Policy	Revisions
March 21, 2013	Pneumatic Compression Devices	LCD Revision Effective Date: 01/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" HCPCS CODES AND MODIFIERS: Added: E0670 DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Changed: Word "Patient" to "Beneficiary Policy Article Revision Effective Date: 04/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement
March 21, 2013	Pressure Reducing Support Surfaces – Group 3	LCD Revision Effective Date: 01/01/2011 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order prior to delivery" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Written Order Prior To Delivery heading

Date	Policy	Revisions
March 28, 2013	Enteral Nutrition	LCD Revision Effective Date: 05/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Changed: Word "Patient" to "Beneficiary" Added: Verbiage regarding allowances under the Refill Requirement section. DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Added: 5th bullet under revised DIF requirements Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Changed: Word "Patient" to "Beneficiary"
March 28, 2013	Heating Pads and Heat Lamps	LCD Revision Effective Date: 04/01/2011 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Changed: Word "Patient" to "Beneficiary" Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement
March 28, 2013	Intrapulmonary Percussive Ventilation System	LCD Revision Effective Date: 07/01/2007 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" DOCUMENTATION REQUIREMENTS: Changed: Word "Patient" to "Beneficiary" Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement

Date	Policy	Revisions
March 28, 2013	Pressure Reducing Support Surfaces – Group 1	LCD Revision Effective Date: 01/01/2011 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Removed: Requirement for the Statement of Certifying Physician (effective April 1, 2013) Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Changed: Word "Patient" to "Beneficiary"
March 28, 2013	Speech Generating Devices	LCD Revision Effective Date: 01/01/2011 (March 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard Language Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Changed: "DME" to "equipment" CODING GUIDELINES: Changed: Word "Patient" to "Beneficiary"

Date	Policy	Revisions
April 4, 2013	High Frequency Chest Wall Oscillation Devices	LCD Revision Effective Date: 05/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Added: Standard therapy coverage criteria documentation Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Benefit category statement
April 4, 2013	Oral Anticancer Drugs	LCD Revision Effective Date: 05/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Changed: Word "Patient" to "Beneficiary" Revised: Language for clarification and addition of CMS IOM references DOCUMENTATION REQUIREMENTS: Added: Dosage strength for J8999 (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Language for clarification and addition of CMS IOM references Clarified: Billing information on units of service. Added: Reference to the "NDC/HCPCS Crosswalk" on PDAC website

Date	Policy	Revisions
April 4, 2013	Orthopedic Footwear	LCD Revision Effective Date: 10/01/2009 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 04/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble Added: DME benefit category statement Updated: LCD title for Therapeutic Shoes for Persons with Diabetes
April 4, 2013	Respiratory Assist Devices	LCD Revision Effective Date: 06/01/2013 COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" Added: Refill requirements Added: Replacement requirement clarification allowing use of pre-Medicare testing DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 06/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement

Date	Policy	Revisions
April 4, 2013	Wheelchair Seating	LCD Revision Effective Date: 05/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: Arthrogryposis, osteogenesis imperfecta, spinocerebellar disease and transverse myelitis to the list of covered conditions for skin protection seat cushions Changed: Word "Patient" to "Beneficiary" ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: Added: 323.82, 334.0-334.9, 728.3, 754.89, 756.51 to HCPCS codes set E2603, E2604, E2622, E2623 DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 05/01/2013 CODING GUIDELINES: Changed: Word "Patient" to "Beneficiary" Added: Adjustable seat narrative incorporated from "Change to Wheelchair Cushion HCPCS Codes" originally published 12/14/2004 and reposted by the PDAC August, 2008
April 11, 2013	Cold Therapy	LCD Revision Effective Date: 01/01/2011 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirements language to specify a "detailed written order" Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Benefit category statement
April 11, 2013	Negative Pressure Wound Therapy Pumps	LCD Revision Effective Date: 10/01/2011 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language

Date	Policy	Revisions
April 11, 2013	Refractive Lenses	LCD Revision Effective Date: 05/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" HCPCS MODIFIERS: Added: GY modifier DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Added: GY modifier instruction Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Benefit category statement Changed: Word "Patient" to "Beneficiary"
April 11, 2013	Therapeutic Shoes for Persons with Diabetes	LCD Revision Effective Date: 02/04/2011 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 05/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement CODING GUIDELINES: Changed: Word "Patient" to "Beneficiary"
April 18, 2013	Oral Antiemetic Drugs	LCD Revision History Effective Date: 01/01/2012 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Clarified: Detailed written order requirements Added: Reference to CMS Benefit Policy Manual

Date	Policy	Revisions
April 18, 2013	Parenteral Nutrition	LCD Revision Effective Date: 02/04/2011 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Order requirement language to specify a "detailed written order" Changed: Word "Patient" to "Beneficiary" Added: Refill requirements DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 05/01/2013 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Benefit category statement Changed: Word "Patient" to "Beneficiary"
April 18, 2013	Power Mobility Devices	LCD Revision Effective Date: 06/01/2011 (April 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Changed: Word "Patient" to "Beneficiary" DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference) Added: Standard language Policy Article Revision Effective Date: 05/01/13 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble and benefit category statement Changed: Word "Patient" to "Beneficiary"

Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios

Question:

What date should be reported on the 7-element order for the face-to-face (F2F) examination for power mobility devices (PMDs)?

Response:

The required PMD F2F examination has two components. These components are:

1. Decision component – An in-person visit between the beneficiary and the ordering physician to document the decision to order a PMD; and,
2. Medical evaluation component – A medical examination to document the beneficiary's mobility and functional condition.

Both components are required and must be documented in the prescribing physician's records.

Several possible scenarios can affect the determination of the correct F2F examination date.

F2F Scenarios

The ordering physician completes the entire F2F examination (both #1 & #2 above) during the initial, in-person encounter with the beneficiary. If this is the case, the date of the F2F examination is the date of that in-person encounter.

- The ordering physician has an initial in-person encounter with the beneficiary (#1 above) but does not complete the medical evaluation component (#2 above) of the F2F examination at this initial visit. At a subsequent visit with the ordering physician, the medical evaluation component is completed. In this situation, the date of the F2F examination is the date of the subsequent in-person encounter when the medical evaluation is completed.
- The ordering physician completes the decision component (#1 above) of the F2F examination at the initial in-person encounter with the beneficiary. The beneficiary is referred to another licensed clinical medical professional (LCMP) such as an Occupational Therapist (OT) or Physical Therapist (PT), who has experience and training in mobility evaluations, to perform all or a portion of the medical evaluation component (#2 above) of the F2F examination. The physician must indicate concurrence or any disagreement with the information in the written evaluation, sign and date the document. The F2F date listed on the 7-element order is the date the physician signed, dated and indicated concurrence or disagreement with the LCMP mobility evaluation.
- The ordering physician refers the beneficiary to an LCMP prior to the in-person encounter (#1 above) with the beneficiary. Once the physician has received and reviewed (stated concurrence, signed, and dated) the written report of the LCMP medical examination (#2 above), the physician must see the beneficiary and complete the decision component (#1 above). In this scenario, the date of the F2F examination reported on the 7-element order would be the date of the in-person encounter between the physician and beneficiary.
- The F2F examination is performed and completed during an inpatient hospital or nursing home stay, the date of the F2F examination reported on the 7-element order is either: 1) the date that both components 1 and 2 above are completed; or, 2) the date of discharge.
- The F2F examination has been completed, but the physician later identifies that there is information not properly documented in the medical record about the beneficiary which is necessary to support coverage criteria for a PMD. If the physician provides an amendment, correction or addenda to the F2F examination with information that arose from the previously performed F2F evaluation (both #1 & #2 above), the F2F examination date does not change on the 7-element order. The amendment, correction or addenda to the F2F evaluation should appear in the beneficiary's medical record.
- The F2F examination has been completed, but the physician later identifies that there is information that was not addressed during the F2F examination (both #1 & #2 above) which is necessary to support coverage criteria for a PMD. The physician must provide this new information in the medical record but since this was not a part of the original F2F, this does require a new in-person visit for the patient with the physician. This new F2F visit date becomes the F2F date on the 7-element order.

If the date of the F2F examination is entered incorrectly or if any other information on the 7-element order must be corrected, it is recommended the supplier request that the physician who completed the original 7-element order complete a new 7-element order. However, if a new 7-element order cannot be obtained, a corrected 7-element order is acceptable only when properly corrected/amended by the physician who originally signed it.

Any deletion and/or addition made to the 7-element order must be entered only by the physician who created the original 7-element-order, who must legibly sign and date the change.

In addition, a corrected 7-element-order is acceptable only when the corrections/amendments are made prior to the completion of any detailed product description and prior to the date of service of the claim.

Suppliers are encouraged to review the Program Integrity Manual available on the Centers for Medicare & Medicaid Services website for additional information on amendments, corrections and delayed entries in medical documentation. This can be found in publication 100-08, chapter 3, section 3.3.2.5.

Additional information on how to change a 7-element order can be found in an article titled, "Changing a 7-Element-Order for a Power Mobility Device", available on the Noridian website. Suppliers can obtain additional information regarding medical necessity and documentation requirements for Power Mobility Devices in the Power Mobility Devices Local Coverage Determination (L23598) and Policy Article (A41127) which are also available on the Noridian website.

K0009 Manual Wheelchair – Coding Verification Review Requirement – Update

It has been previously communicated that Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) products listed on the PDAC website with HCPCS code K0009 (OTHER MANUAL WHEELCHAIR/BASE) would be end dated March 31, 2013. The new effective end date for all products currently coded under K0009 is May 31, 2013. Manufacturers that submitted a coding verification application to the PDAC prior to December 3, 2012, were notified on April 12, 2013 of the coding verification results.

Effective for claims with dates of service on or after June 1, 2013, the only products which may be billed to Medicare using code K0009 are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification List in DMECS maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code E1399.

The PDAC coding verification application required for these products is the Manual Wheelchairs application. This application is located on the PDAC website, https://www.dmepdac.com/review/apps_check.html.

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

Manual Wheelchair Local Coverage Determination and Policy Article – Revised

The Manual Wheelchair Bases LCD and Related Policy Article have been revised, effective for dates of service on or after March 1, 2013. The INDICATIONS AND LIMITATIONS OF COVERAGE section of the LCD was revised regarding the coverage criteria for codes K0005 and E1161 to reflect their classification as complex rehabilitation equipment and to conform with the DMEPOS Quality Standards. The CODING GUIDELINES section of the Manual Wheelchair Bases related Policy Article was revised to clarify the use of weight in the classification of manual wheelchair bases. In addition, the revision provides guidance on the proper coding of E1161 based on the degree of tilt.

Suppliers are advised to refer to the Manual Wheelchair Bases LCD and Related Policy Article for additional coverage, coding and documentation requirements information.

Notification of Widespread Prepayment Review – Power Mobility Devices

Noridian Jurisdiction D, DME MAC Medical Review, will be initiating a widespread prepayment review of billed power mobility devices when a change in medical need has been indicated.

Widespread prepayment 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 the results of CERT review analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for power mobility devices when a change in medical need has been indicated 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 7-element order for a power mobility device; and,
- Face-to-face evaluation, completed prior to the 7-element order, which supports the medical necessity for the power mobility device. This evaluation should provide the condition and progression of disease over time. It should clearly indicate ambulatory status, why a power mobility device is needed as compared to a cane, walker, or manual wheelchair, and address the medical justification for each accessory billed. Other medical records (physical and occupational therapy notes, physician office records, hospital records, home health agency records, etc) may be submitted to supplement the information in the face-to-face evaluation; and,
- Medical documentation to support a change in the beneficiary's condition to warrant a different item than the item on file; and,
- For codes K0835–K0843; K0848–K0855; K0890–K0891; K0898: A specialty wheelchair evaluation completed by PT/OT or a physician trained in rehabilitation wheelchair evaluations (must be signed and dated by the attending physician if used as part of the face-to-face evaluation); and,
- Documentation to support the practitioner completing the specialty evaluation has no financial relationship with the supplier; and,
- For codes K0835–K0843; K0848–K0855; K0890–K0891; K0898: Documentation that the supplier employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary; and,
- Detailed product description listing all items/options/upgrades; and,
- Home assessment indicating the power mobility device is able to access all rooms of the home; and,
- Signed and dated delivery documentation with beneficiary's name and address and the description (manufacturer, model number, etc) of the equipment provided; and,
- The Advanced Beneficiary Notice (ABN), if applicable.

Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be either handwritten OR electronic signature. Stamp signatures are not acceptable.

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 Administrative Services LLC P.O. Box 6727 Fargo, ND 58108-6727.

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127. Suppliers also need to be familiar with the Wheelchair Options/Accessories LCD L11462 and Policy Article A19846, and the Wheelchair Seating LCD L15670 and Policy Article A17265.

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

Revised – Power Mobility Device Independent Testing Requirements

Overview

The Pricing, Data Analysis and Coding (PDAC) contractor is providing this additional information to clarify the Medicare code verification process for Power Mobility Devices (PMDs).

The requirements for safety and performance-testing of PMDs, or power wheelchair models and power operated vehicle (scooter) models, changed effective January 1, 2008.

The PDAC requirements assure Medicare and its beneficiaries have access to verifiable safety and performance test results when selecting an appropriate power wheelchair or scooter to meet their clinical needs. For Medicare, independent testing assures appropriate payment based on quantifiable safety and performance test results for each product model. Safety and performance testing of power wheelchairs and scooters is part of the current Healthcare Common Procedure Coding System (HCPCS) code verification process. The PDAC uses the device test results, device characteristics, power options, patient weight capacity, and seating options to assign products to the PMD HCPCS codes implemented on November 15, 2006.

Independent Testing Requirements

Code verification applications for PMDs that were submitted and completed prior to January 1, 2008, were allowed to have safety and performance testing conducted at manufacturer test facilities.

Code verification applications submitted on/or after January 1, 2008, are required to have Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) tests conducted at a RESNA-capable testing facility. Wheelchairs are classified under HCPCS coding based on the direct results of tests that meet RESNA standards. No other tests or testing standards may be used. If it is found that the testing is not compliant with RESNA standards, the PDAC coding verification application will be rejected. NOTE: The following exception applies:

The drop test and the fatigue test may be conducted at manufacturer testing facilities.

Manufacturer Testing of Power Mobility Devices

Code verification applications submitted to the PDAC must contain thoroughly documented RESNA test data. Test results are subject to review and observation by CMS and its contractors, including requests for additional documentation; such as testing instruments utilized, testing instrument calibration records and/or reports, certification and training qualifications of personnel performing the tests, and the RESNA standards observed.

Manufacturers may continue to perform multi-drum and curb drop fatigue cycle testing as long as the tests are conducted using the latest RESNA protocols, and conducted in a testing facility with equipment and personnel capable of performing the testing in accordance with RESNA standards and parameters. Manufacturers shall continue to provide an attestation from senior management (CEO and/or President or Vice President only) that the manufacturer has performed the PMD testing in accordance with RESNA testing standards. The manufacturer must further certify that the personnel who performed the tests had the training and qualification necessary to be fully knowledgeable of RESNA testing standards, and were capable of conducting the tests in accordance with the required RESNA testing standards. This certification must accompany the code verification request.

Power Mobility Devices Submitted for Independent Testing

For all new PMD models, a full production model PMD available for sale to the public must be submitted to an independent testing facility.

PMD prototypes, customized models, pre-production models and any other design phase type models are not acceptable for Medicare safety and performance testing, nor may any of these be furnished to Medicare beneficiaries.

All new PMD models are required to be tested according to the latest RESNA methods, formulae, and protocols. The latest RESNA test procedures are : RESNA WC-1:2009 – RESNA American National Standard for Wheelchairs – Volume 1: Requirements and Test Methods for Wheelchairs (Including Scooters) and RESNA WC-2:2009 – RESNA American National Standard for Wheelchairs – Volume 2: Additional Requirements for Wheelchairs (Including Scooters) with Electrical Systems.

All PMDs must be tested at the maximum patient weight capacity for the base. RESNA has defined the chair configuration for testing and clarified test protocols. All parameters and technical information needed to conduct the testing may be obtained from RESNA at www.resna.org.

Medicare does not specifically endorse the following testing facilities, however the facilities below are identified on the RESNA website as being RESNA capable Powered Mobility Device testing facilities:

University of Pittsburgh School of Health and Rehabilitation Sciences Department of Rehabilitation Sciences and Technology 4020 Forbes Tower Pittsburgh, PA 15260 Phone: 412.383.6558 http://www.shrs.pitt.edu/	Ammer Consulting 1050 Saxonburg Blvd. Glenshaw, PA 15116 Phone: 412.389.4429 bill@ammerconsulting.com http://ammerconsulting.com/_wsn/page3.html
Beneficial Designs Inc PO Box 69 Minden, NV 89423 Phone: 775.783.8822 http://beneficialdesigns.com/	

Supplemental PMD Safety and Performance Testing Information

The following RESNA test protocols are listed for your convenience. The bolded and underlined titles represent the subsections required to be tested and results that must be submitted to the PDAC. Some RESNA test sections that are not required are listed for reference in the test protocols for the purposes of clarity. Other RESNA test sections are listed only for convenience. The protocol documents to be used are always the most recent RESNA standards. The manufacturer may perform only Section 8, Tests 10.4(Multi-Drum) and 10.5(Curb Drop) from Volume 1. All other tests are to be performed by an independent test facility. Each test report must contain a photograph of each configuration of the wheelchair during testing and minimum of one photograph of each test setup. The test report shall also include a list of equipment used. (meters, gauges, measuring instruments). Calibration data for all equipment must also be supplied.

Copies of the Resna Standards may be ordered from:
RESNA
1700 N. Moore St., Suite 1540, Arlington, VA 22209-1903
PHONE: 703/524-6686 FAX: 703/524-6630 TTY: 703/524-6639
WEB SITE: www.resna.org EMAIL: publications@resna.org

Volume 1: Requirements and Test Methods for Wheelchairs (including POVs)

Section 1: Determination of Static Stability

Static Stability of Chairs with Power Options:

Section 1 – 10.3: Rearward Stability with wheels locked (If there are non- locking casters to the rear, use 10.2 Rearward Stability with wheels unlocked)

Section 1 – 11.2: Rearward Anti-tip stability with wheels locked (could be rearward, forward, or both depending on where the anti-tip devices are placed)

Section 5: Determination of Dimensions, Mass and Maneuvering Space

Length – Section 5 – 8.2 – Full overall length – including a foot space gauge on the foot supports. The new test procedure includes feet on the chair to simulate the space required by user with feet on the foot supports. Record and disclose the length with and without the foot space gauge.

Width – Section 5 – 8.3 – Full overall width

Pivot Width – Section 5 – 8.11 – Pivot width – this is the turning radius for a power wheelchair with joystick steering.

Reversing Width – Section 5 – 8.12 – This is a three-point turn and applies to a POV with tiller steering.

Corridor Turn test – Section 5 – 8.15 – Width of angled corridor required to determine the minimum width of hallway needed for the device to turn around.

Section 7: Method of Measurement of Seating and Wheel Dimensions Seating Measurements for Coding

7.3.2 Seat Plane Angle

7.3.3 Effective Seat Depth

7.3.4 Seat Width

7.3.6 Seat Surface Height at Front Edge

7.3.7 Back Support Angle

7.3.8 Back Support Height

Section 8: Requirements and Test Methods for Static, Impact and Fatigue Strengths

Fatigue Test on Level with Slats – Section 8:

10.4 Multi-Drum Test

Drop Cycles – Section 8:

10.5 Drop Test

Section 11: Test Dummies

Section 13: Determination of Coefficient of Friction of Test Surfaces

Section 15: Requirements for Information Disclosure, Documentation and Labeling

Section 16: Resistance to Ignition of Upholstered Parts-Requirements and Test Methods

Section 19: Requirements and test Methods for Wheelchairs (including POVs): Wheelchairs

Used as Seats in Motor Vehicles (selected models only)

Section 20: Determination of the Performance of Stand-Up Type Wheelchairs

Section 22: Set Up Procedures

Section 26: Vocabulary

Volume 2: Additional Requirements for Wheelchairs (including POVs) with Electrical Systems

Section 2: Determination of Dynamic Stability of Electric Wheelchairs

Dynamic Stability Incline

Section 2 – Driving Tests on Slopes and Level – Maximum slope the chair passes all tests with a score of 2 or better.

Clause 8 Tests for rearward dynamic stability – 3 tests

8.2 Starting forwards

8.3 Stopping after traveling forwards

8.4 Braking when traveling backwards

Clause 9 – Tests for forward dynamic stability – 2 tests

9.2 Braking when traveling forwards

9.3 Traveling forward down a slope onto a horizontal surface

Clause 10 – Tests for dynamic stability in lateral directions – 2 tests

10.2 Turning on a slope

10.3 Turning in a circle at maximum speed (applies only to POVs) Disclosure

10.4 Turning suddenly at maximum speed (applies to PMD with joystick steering)

Section 2 – Step Transition Tests – Maximum step transition height that chair can pass all related stability tests with a score of 2 or better.

Clause 8 Tests for rearward dynamic stability – 2 tests

8.5 Traveling forward up a step transition from a standing start,

8.6 Traveling backward down a step transition from a standing start

Clause 9 – Tests for forward dynamic stability – 2 tests

9.4 Traveling forward up a step transition at maximum speed,

9.5 Traveling forward down a step transition from a standing start

Clause 10 – Tests for dynamic stability in lateral directions – 1 test

10.5 One side of the wheelchair drops down a step transition

Section 3: Determination of Effectiveness of Brakes

Section 4: Energy Consumption of Electric Wheelchairs and POVs for Determination of Theoretical Distance Range

Theoretical Driving Range – Section 4 – 7.1 – this test calculates the maximum distance potentially available on a fully charged battery under ideal conditions.

Theoretical Maneuvering Range – Section 4 – 7.2 Maneuvering test – this test simulates range of the device when required to turn.

Section 6: Determination of Maximum Speed, Acceleration and Deceleration of Electric Wheelchairs

Minimum Top End Speed – Flat – Section 6 – 6.1 Determination of Maximum speed on a horizontal surface

Maximum Top End Speed On Slope – Section 6 – 6.5 Maximum speed on a slope. Testing is done on the same slope used for the dynamic stability slope.

Section 9: Climatic Tests for Electric Wheelchairs

Section 10: Determination of Obstacle-Climbing Ability of Electrically Powered Wheelchairs

Obstacle Height – Section 10 – Clause 7 – Maximum obstacle height to ascend and descend with technique described.

Section 14: Power and Control Systems for Electric Wheelchairs-Requirements and Test Method

Maximum Thermal Drive Test – Section 14 – 6.18 Maximum Thermal Drive-Test discloses maximum driving time and driving distance uphill

Maximum Power Stall Condition – Section 14 – 6.14 Stalled Condition

Protection –This test ensures that the device has protection at the controller for the motors if someone tries to drive when stuck.

Section 21: Requirements and Test Methods for Electromagnetic Compatibility of Electrically Powered Wheelchairs and Motorized POVs

Published by Palmetto GBA as the SADMERC, December 2007. Republished by Noridian as the PDAC, August 2008. Revised by Noridian as the PDAC, March 2010.

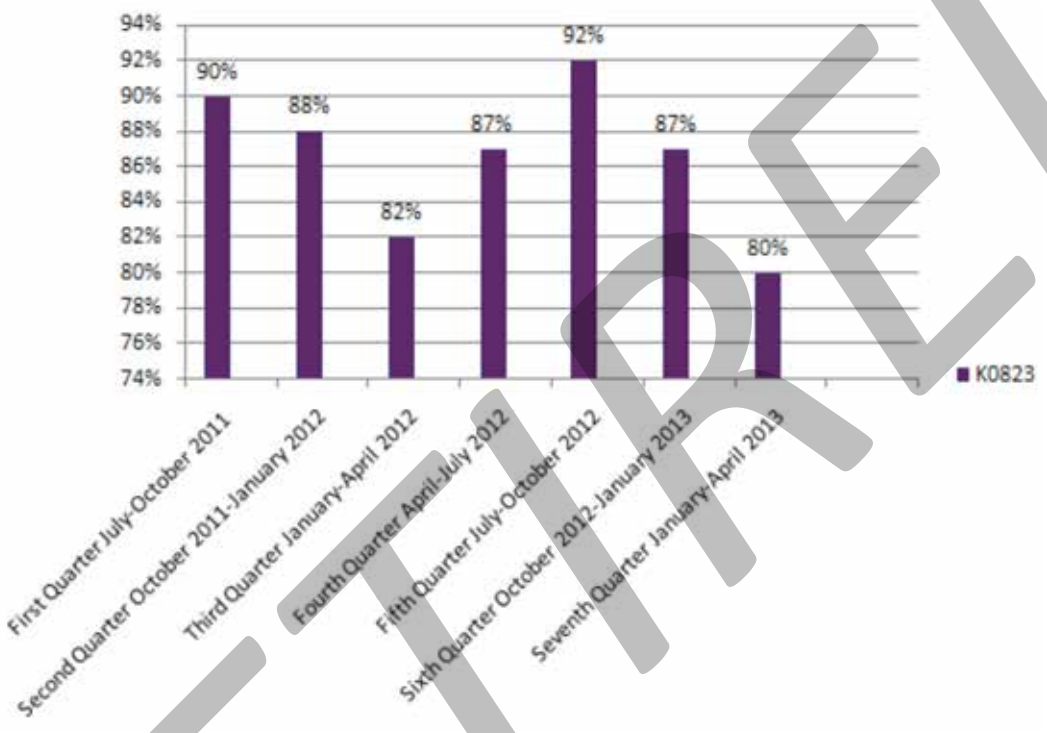
Seventh Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0823 and All Related Accessories)

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 seventh quarter edit effectiveness results from January 2013 through April 2013 are as follows:

The K0823 review involved 651 claims of which 520 were denied. This resulted in an overall error rate of 80%.

Historical Data of the Error Rate for K0823 Review



Primary Documentation Errors that Resulted in Denial of Claims

27% of K0823 claims received a denial as 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.

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.

10.64% of K0823 claims received a denial as 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.

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

8.56% of K0823 claims received a denial as there was no detailed product description or the detailed product description submitted was invalid.

LCD L23598 states, "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. 100-08) 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 power wheelchair (PWC) or power operated vehicle (POV). A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request.

7.48% of K0823 claims received a denial as medical records do not support that the beneficiary is unable to safely transfer to and from a POV, or operate the tiller, or maintain postural stability while operating a POV.

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

D. The beneficiary is able to:

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

Going Forward

Based on the results of the review, Noridian will continue with the prepayment widespread review.

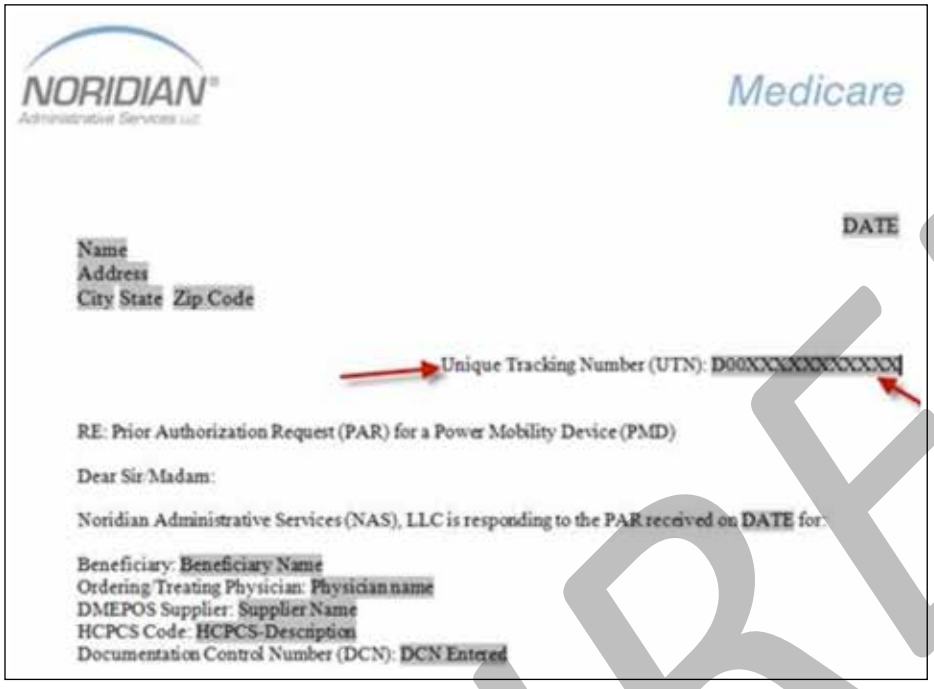
Education Resources

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 (PA) A41127.

Suppliers can also review specific policy resources for power mobility devices on the Noridian website at https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html. There, you will find information related to proper documentation requirements including a physician letter, documentation.

Submitting PMD Claims Following Prior Authorization Decision

The submission of a prior authorized Power Mobility Device (PMD) claim must contain the 14 byte unique tracking number (UTN) that is located on the prior authorization decision letter.



NORIDIAN Administrative Services LLC

Medicare

DATE

Name
Address
City State Zip Code

Unique Tracking Number (UTN): D00XXXXXXXXXXX

RE: Prior Authorization Request (PAR) for a Power Mobility Device (PMD)

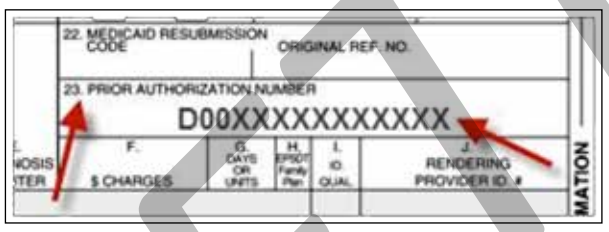
Dear Sir/Madam:

Noridian Administrative Services (NAS), LLC is responding to the PAR received on DATE for:

Beneficiary: Beneficiary Name
Ordering/Treating Physician: Physician name
DMEPOS Supplier: Supplier Name
HCPCS Code: HCPCS-Description
Documentation Control Number (DCN): DCN Entered

Paper Submission

For submission of paper claims, the UTN must be entered in Item 23 of the 1500 Claim Form. In cases where the UTN is not included in Item 23, the claim will be selected for complex medical review.



22. MEDICAID RESUBMISSION CODE
ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
D00XXXXXXXXXXX
F. $ CHARGES
G. DAYS OR UNITS
H. EPSDT Family Plan
I. ID. QUAL
J. RENDERING PROVIDER ID. #
MATION

Electronic Submission

For submission of electronic claims the UTN must be entered at either loop 2300 REF02 (REF01=G1) or loop 2400 REF02 (REF01=G1). In cases where the UTN is not included in loop 2300 REF02 (REF01=G1) or loop 2400 REF02 (REF01=G1), the claim will be selected for complex medical review.

Fifth Quarter Results of Widespread Prepayment Review of Claims for Nebulizer Drugs (HCPCS J7626 and J7605)

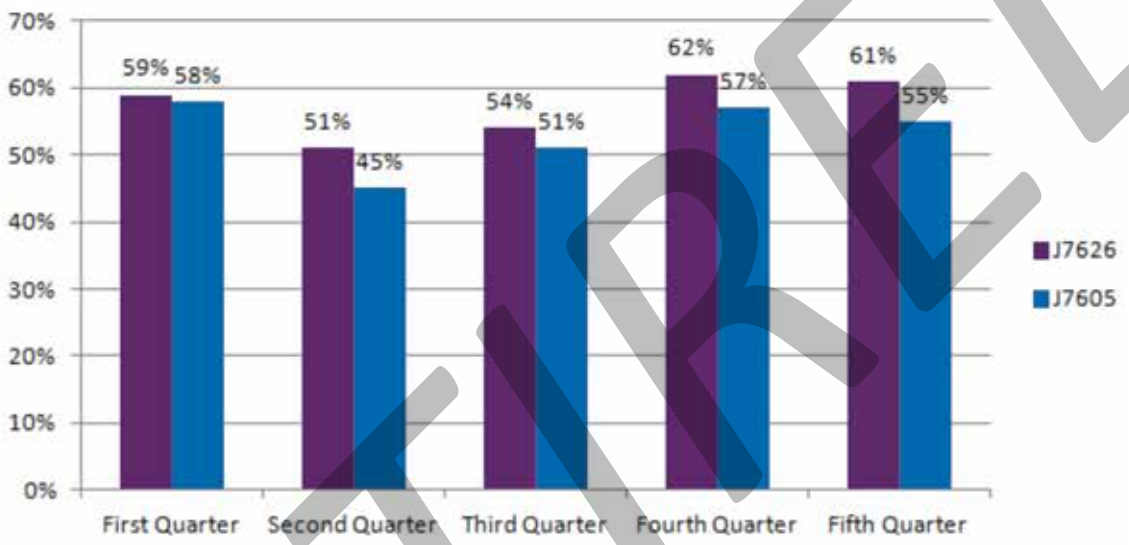
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is currently conducting a widespread complex review of HCPCS codes J7626 and J7605. The fifth quarter edit effectiveness results from September 2012 through November 2012 are as follows:

The J7626 review involved 2,443 claims of which 1,472 were denied. This resulted in an overall error rate of 61%.

The J7605 review involved 930 claims of which 504 were denied. This resulted in an overall error rate of 55%.

Historical Data of the Error Rate for J7626 and J7605 Review



Primary Documentation Errors that Resulted in Denial of Claims

A denial resulted due to no response to the additional documentation request letter within the allotted timeframe.

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. 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.

A denial resulted as documentation did not support refill requirements.

The Program Integrity Manual chapter 5 section 5.2.6 states, "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. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply."

A denial resulted due to not receiving medical records or office notes.

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.

A denial resulted due to not receiving proof of delivery documentation to meet Medicare requirements.

Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for seven years. Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR, 424.57(12). Proof of delivery documentation must be made available to the DME MAC, DME PSC, and ZPIC upon request. 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 shall be the date of service on the claim.

Going Forward

Due to the persistently high error rate and the technical nature of the errors, Noridian is closing the complex medical review and initiating a widespread documentation compliance review for nebulizer drugs. Additional documentation request (ADR) letters will be sent as claims are selected randomly for this review.

Education Resources

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

Suppliers can also review specific policy resources for Nebulizer Drugs on the Noridian website at Nebulizers 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 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

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L4360, L1970 and L1960. The first quarter edit effectiveness results from December 2012 through March 2013 are as follows:

The L4360 review involved 564 claims of which 474 were denied. This resulted in an overall error rate of 84%.

The L1970 review involved 63 claims of which 53 were denied. This resulted in an overall error rate of 86%.

The L1960 review involved 109 claims of which 87 were denied. This resulted in an overall error rate of 80%.

Primary Documentation Errors that Resulted in Denial of Claims

- **23% of L4360 claims received a denial as no proof of delivery submitted.**
- **7% of L1970 claims received a denial as no proof of delivery submitted.**

No proof of delivery submitted.

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

22% of L4360 claims received a denial as no detailed written order or dispensing order received.

No detailed written order or dispensing order received.

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
- **25% of L1970 claims received a denial as the treating physician's records don't provide detailed documentation to support medical necessity of custom rather than prefab orthosis.**
- **22% of L1960 claims received a denial as the treating physician's records don't provide detailed documentation to support medical necessity of custom rather than prefab orthosis.**

The treating physician's records don't provide detailed documentation to support medical necessity of custom rather than prefab orthosis.

For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support the medical necessity of custom-fabricated rather than a prefab orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

- **22% of L1970 claims received a denial as criteria 1,2,3,4 OR 5 not met.**
- **21% of L1960 claims received a denial as criteria 1,2,3,4 OR 5 not met.**

Criteria 1,2,3,4 OR 5 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:

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

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

- **19% of L4360 claims received a denial as documentation insufficient to support basic coverage criteria.**
- **17% of L1960 claims received a denial as documentation insufficient to support basic coverage criteria.**
- **13% of L1970 claims received a denial as documentation insufficient to support basic coverage criteria.**

Documentation insufficient to support basic coverage criteria.

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

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 Ankle-Foot/Ankle-Knee-Foot Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review specific policy resources for Ankle-Foot/Ankle-Knee-Foot on the Noridian website at https://www.noridianmedicare.com/dme/train/. There, you will find, information related to FAQs, and a presentation used during Web-based workshops.

Noridian Administrative Services' 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

First 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 January 2013 through March 2013 are as follows:

The L8030 review involved 317 claims of which 219 were denied. This resulted in an overall error rate of 68%.

Primary Documentation Errors that Resulted in Denial of Claims

- 21% 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.

- 14% 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.

- 9% of L8030 claims received a denial as documentation did not support continued need.

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

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

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

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

- 7% 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.

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 External Breast Prostheses Local Coverage Determination (LCD) L11569 and Policy Article A19833.

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

Results of Widespread Prepayment Probe Review of Lower Limb Prostheses (HCPCS L5673 and L5301)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes L5673 and L5301. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The L5673 review involved 100 claims of which 79 were denied. This resulted in an overall error rate of 79%.

The L5301 review involved 100 claims of which 80 were denied. This resulted in an overall error rate of 80%.

Primary Documentation Errors that Resulted in Denial of Claims

- 18% of L5673 claims received a denial as documentation did not support criteria 1.
- 13% of L5301 claims received a denial as documentation did not support criteria 1.

A lower limb prosthesis is covered when the beneficiary:

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

- 18% of L5673 claims received a denial as documentation did not support criteria 2.
- 13% of L5301 claims received a denial as documentation did not support criteria 2.

A lower limb prosthesis is covered when the beneficiary:

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

- 15% of L5673 claims received a denial as no documentation from the physician was submitted.
- 12% of L5301 claims received a denial as no documentation from the physician was 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.

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

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.
- 8% of L5673 claims received a denial as no documentation was received.
- 13% of L5301 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

Noridian Administration Services will close this probe review.

Education Resources

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

Noridian Administrative Services' 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

Refunds to Medicare

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

OXYGEN

Third Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment billed with RA Modifier (HCPCS E1390 and E0431)

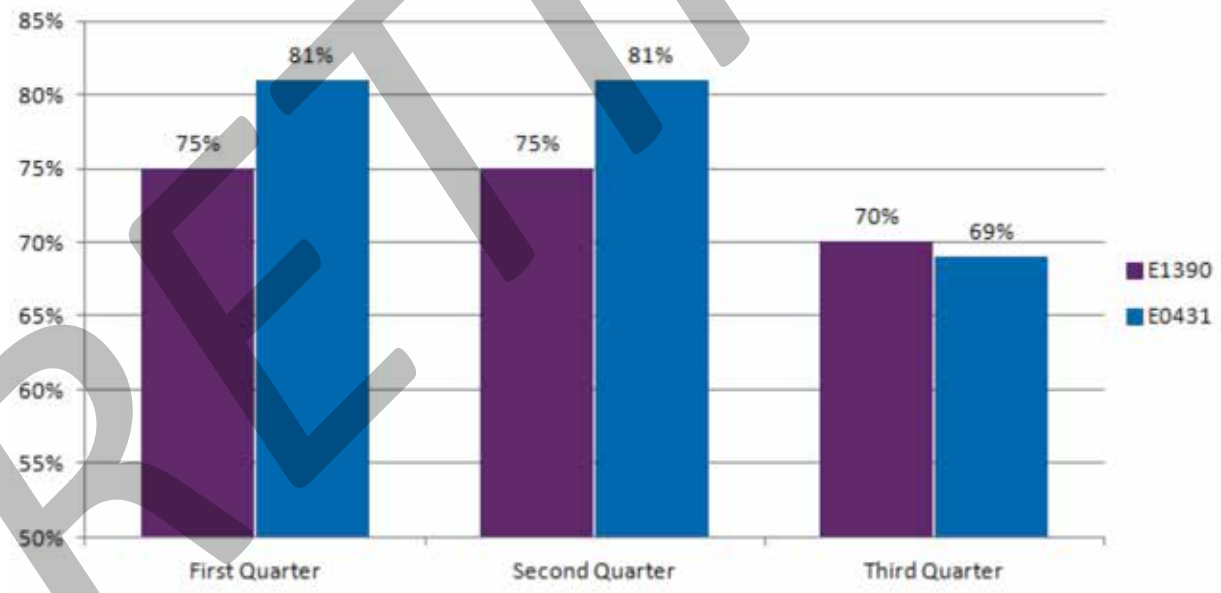
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E1390 and E0431. The third quarter edit effectiveness results from November 2012 through February 2013 are as follows:

The E1390 (with the RA modifier) review involved 371 claims of which 261 were denied. This resulted in an overall error rate of 70%.

The E0431 (with the RA modifier) review involved 108 claims of which 76 were denied. This resulted in an overall error rate of 69%.

Historical Data of the Error Rate for E1390 (RA) and E0431 (RA) Review



Primary Documentation Errors that Resulted in Denial of Claims

- **25% of E1390 (RA) claims received a denial as no documentation was provided to support the continued need of oxygen.**
- **20% of E0431 (RA) claims received a denial as no documentation was provided to support the continued need of oxygen.**

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

For DMEPOS items for which there is on-going use, 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 continued to remain reasonable and necessary. Information used to justify this continued need must be timely for the DOS under review.

- **25% of E1390 (RA) claims received a denial as no documentation was provided to support continued use of oxygen.**
- **20% of E0431 (RA) claims received a denial as no documentation was provided to support continued use of oxygen.**

Continued use describes the ongoing utilization of an item or service by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS items and must discontinue billing Medicare when an item is no longer being used by the beneficiary. Ongoing use must be periodically documented. Either beneficiary medical records or supplier records are sufficient to confirm that the DME POS item continues to be used by the beneficiary.

- **12% of E1390 (RA) claims received a denial as no documentation was received.**
- **14% of E0431 (RA) 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 E1390 (RA) claims received a denial as no medical documentation was provided to support the blood gas study documented on the CMN.**
- **14% of E0431 (RA) claims received a denial as no medical documentation was provided to support the blood gas study documented on the CMN.**

For certification for replacement equipment, repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.

If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record. However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient'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).

Going Forward

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

OXYGEN

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 Local Coverage Determination (LCD) L11457 and Policy Article A33677.

Suppliers can also review specific policy consolidated resources for Oxygen and Oxygen Equipment on the Noridian website at https://www.noridianmedicare.com/dme/coverage/lcd.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 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

PDAC

Items Requiring Coding Verification Reviews by PDAC

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

The table below reflects the current list of HCPCS codes that require coding verification review by the PDAC along with the applicable LCD or Advisory Article for the code(s) and the date (i.e., claims with dates of service on or after) for when the requirement became effective.

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS		
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	4/1/2012
ENTERAL NUTRITION		
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G. GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G. GLUTAMINE, ARGININE), FAT (E.G. MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATION, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
KNEE ORTHOTICS		
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/08
MANUAL WHEELCHAIR BASES		
K0009	OTHER MANUAL WHEELCHAIR/BASE	6/1/13
NEGATIVE PRESSURE WWOUND THERAPY PUMPS		
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	1/1/06
NEBULIZERS		
E0574	ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER	4/1/11
ORAL APPLIANCES		
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	9/1/11
OXYGEN AND OXYGEN EQUIPMENT		
E1405	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY	1/1/06
E1406	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY	1/1/06

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
PATIENT LIFT		
E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENT ACCESSIBLE CONTROLS	1/1/09
E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ ACCESSORIES	1/1/09
E0640	PATIENT LIFT, FIXED SYSTEM, INCLUDES ALL COMPONENTS/ ACCESSORIES	1/1/09
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	1/1/09
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS	1/1/09
PNUEMATIC COMPRESSION DEVICES		
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL	1/1/06
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE	1/1/06
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE	1/1/06
POWER MOBILITY DEVICES		
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	11/15/06
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE	11/15/06
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS	11/15/06
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	11/15/06
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	11/15/06
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	11/15/06
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	11/15/06
PRESSURE REDUCING SUPPORT SURFACES – GROUP 2		
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	1/1/06
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS	1/1/06

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
SPINAL ORTHOSES: TLSO and LSO		
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION	8/31/11
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTEVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0452	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, CUSTOM FABRICATED	7/1/10
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0458	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0462	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0464	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, FOUR RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0470	TLSO, TRIPLANAR CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO SCAPULA, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, ROTATIONAL STRENGTH PROVIDED BY SUBCLAVICULAR EXTENSIONS, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANVERSE PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0472	TLSO, TRIPLANAR CONTROL, HYPEREXTENSION, RIGID ANTERIOR AND LATERAL FRAME EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH WITH TWO ANTERIOR COMPONENTS (ONE PUBIC AND ONE STERNAL), POSTERIOR AND LATERAL PADS WITH STRAPS AND CLOSURES, LIMITS SPINAL FLEXION, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0480	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0482	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0484	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0486	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0488	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0490	TLSO, SAGITTAL-CORONAL CONTROL, ONE PIECE RIGID PLASTIC SHELL, WITH OVERLAPPING REINFORCED ANTERIOR, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES AT OR BEFORE THE T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XIPHOID, ANTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL AND CORONAL PLANES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0491	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0492	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0629	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0632	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0634	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0635	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANEL(S), LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0636	LUMBAR SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANELS, LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0638	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0640	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
SURGICAL DRESSINGS		
A6021	COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH	6/1/13
A6022	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH	6/1/13
A6023	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 48 SQ. IN., EACH	6/1/13
A6024	COLLAGEN DRESSING WOUND FILLER, STERILE, PER 6 INCHES	6/1/13
A6545	GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH	1/1/09

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
THERAPEUTIC SHOES FOR PERSONS WITH DIABETES		
A5512	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH	1/1/06
A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH	1/1/06
WALKERS		
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE	1/1/06
WHEELCHAIR SEATING		
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	7/1/04
E2610	WHEELCHAIR SEAT CUSHION, POWERED	7/1/04
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04

PDAC

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04

The PDAC coding verification applications required for these products are located on the PDAC website at: https://www.dmepdac.com/review/apps_check.html.

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

PECOS

Avoid Denials for Invalid Format of Ordering Physician Names by Using the CMS PECOS List

Suppliers are reminded that the ordering physician name submitted on claims must be the name as provided on the CMS PECOS ordering/referring provider downloadable report, located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html.

Many claims have been submitted using the name as formatted in the NPI registry, which can also be found on-line, which may result in claim denials. Suppliers currently get N544 warning messages on the remittance advice. The data that will be used for editing for DME claims is the CMS PECOS list, not the NPI registry.

Here are some other reminders about the ordering physician name submission:

1. Check the CMS list weekly for newly enrolled providers.
2. Make sure the last name is in the last name field and first name in the first name field. On paper claims (CMS-1500), enter the ordering provider's first name first, and last name second (e.g., John Smith), in Item 17. On electronic claims, ensure that you are not submitting the last name in the first name field and vice versa. Noridian has seen several suppliers who are submitting the ordering physician name backwards.

3. Special characters, such as ' or –, appear in some names on the PECOS list and should be submitted on the claim as such. Spaces must also be present as depicted on the CMS PECOS list.

Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency Claims (Change Requests 6417, 6421, 6696, and 6856)

MLN Matters® Number: SE1305 Revised

Important Announcement on April 25, 2013: Temporary Delay in Implementing Ordering and Referring Denial Edits – Due to technical issues, the implementation of the Phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual National Provider Identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

- **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; and**
- **Claims from Part A Home Health Agencies (HHAs).**

CMS will advise you of the new implementation date in the near future. In the interim, informational messages will continue to be sent for those claims that would have been denied had the edits been in place. Language regarding beneficiary liability has also been updated in this version of the article.

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.

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 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 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, and
- 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.

Important Announcement on April 25, 2013: Temporary Delay in Implementing Ordering and Referring Denial Edits – Due to technical issues, implementation of the Phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual National Provider Identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

- **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; and**
- **Claims from Part A Home Health Agencies (HHA).**

Phase 2: CMS has not determined a date to turn on the Phase 2 edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits.

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; and
- 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, and
- 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

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: 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. **CMS has not determined a date to turn on the Phase 2 edits.**

Below are the denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims.

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:**

a. **You have a current Medicare enrollment record.**

- If you are not sure you are enrolled in Medicare, you may: i. 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;
  - i. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - ii. 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).
  - iii. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

b. **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.
  - i. **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.
  - ii. **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.
  - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
  - iv. 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.
  - v. 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).

c. **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).

d. **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.

e. **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 twice a week 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.

f. **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.

g. **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.

h. **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.

Additional Guidance

1. **Terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.
3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

For more information about the Medicare enrollment process, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf on the CMS website.

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.

PECOS

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.

PRESSURE REDUCING SUPPORT SURFACES

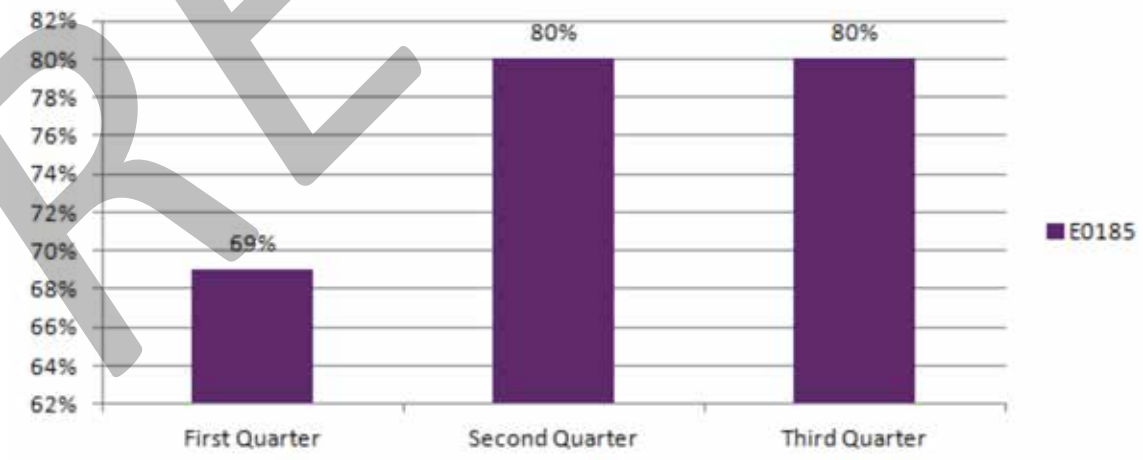
Third Quarter Results of Widespread Prepayment Review of Claims for Group 1 Pressure Reducing Support Surfaces (HCPCS E0185)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0185. The third quarter edit effectiveness results from November 2012 through February 2013 are as follows:

The E0185 review involved 631 claims of which 514 were denied. This resulted in an overall error rate of 80%.

Historical Data of the Error Rate for E0185 Review



Primary Documentation Errors that Resulted in Denial of Claims

35% of E0185 claims received a denial as Criteria 1, 2 or 3 not met.

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

14% of E0185 claims received a denial as Criteria A-D for Criteria 2 and 3 not met.

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):

a. Impaired nutritional status

b. Fecal or urinary incontinence

c. Altered sensory perception

d. Compromised circulatory status

6% of E0185 claims received a denial as order not properly completed.

Per LCD L11578, these items require a written order prior to delivery. Per policy article A33678, for an item addressed in this policy to be covered to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as non-covered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained.

5% of E0185 claims received a denial as no office notes or 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 file by the supplier and be available upon request.

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 Group 1 Pressure Reducing Support Surfaces Local Coverage Determination (LCD) L11578 and Policy Article A33678.

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

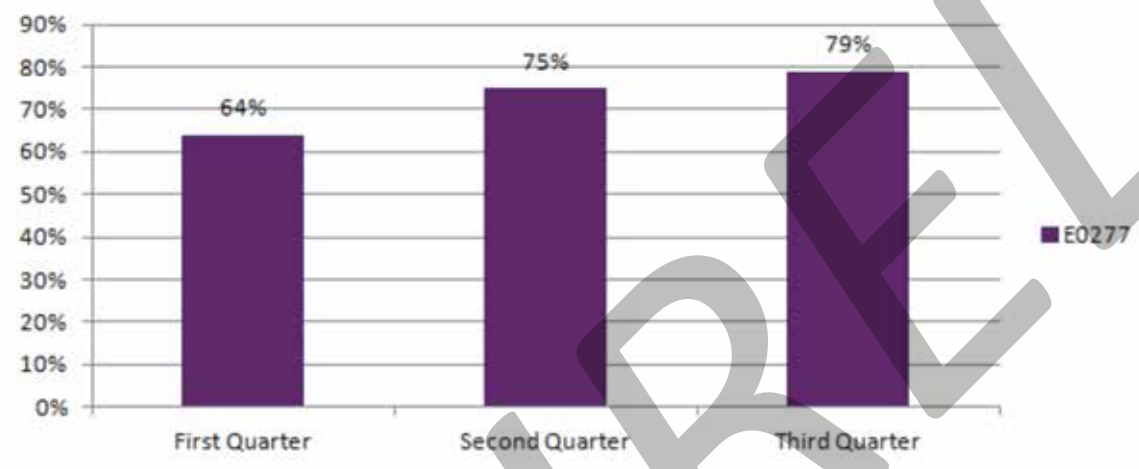
Third Quarter Results of Widespread Prepayment Review of Claims for Group 2 Pressure Reducing Support Surfaces (HCPCS E0277)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0277. The third quarter edit effectiveness results from November 2013 through February 2013 are as follows:

The E0277 review involved 268 claims of which 208 were denied. This resulted in an overall error rate of 79%.

Historical Data of the Error Rate for E0277 Review



Primary Documentation Errors that Resulted in Denial of Claims

- **24% of E0277 claims received a denial as Criterion 1, 2 and 3 not met.**
- **23% of E0277 claims received a denial as Criterion 4 not met.**
- **22% of E0277 claims received a denial as Criterion 5 and 6 not met.**

A group 2 support surface is covered if the patient meets:

a. Criterion 1 and 2 and 3, or

b. Criterion 4, or

c. Criterion 5 and 6.

1. The patient has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02-707.05), and
2. Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface, and
3. The ulcers have worsened or remained the same over the past month, or
4. The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD9- 707.02-707.05), or
5. The patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the last 60 days) (ICD 9- 707.02-707.05), and
6. The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

6% of E0277 claims received a denial as order not properly completed.

Per Policy Article A35422, "For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained."

Going Forward

Based on high error rate, Noridian Administration Services 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 Group 2 Pressure Reducing Support Surfaces Local Coverage Determination (LCD) L11579 and Policy Article A35422.

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

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

When submitting appeal requests for DMEPOS items supplied as refills, the documentation regarding refills, as outlined below, must be submitted with the appeal. In addition, any time that your office receives a request for documentation on a claim, the refill information must be submitted when the item billed on the claim is for a refill.

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.

REFILLS

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

REMITTANCE ADVICES

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM8281
Related Change Request (CR) #: CR 8281
Related CR Release Date: April 12, 2013
Related CR Transmittal #: R2686CP
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8281, which instructs Medicare contractors to make programming changes to incorporate updates to the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs the Fiscal Intermediary Standard System (FISS) and the VIPs Medicare System (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Please make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARC and appropriate RARC that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, Medicare 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.

CR8281 lists only the changes that have been approved since the last code update CR (CR8154, Transmittal 2618, issued on December 21, 2012, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8154.pdf), 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 CR8154

These are the changes in the CARC database since the last code update CR8154. The full CARC list must be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the Internet.

New Codes – CARC: None

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). 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. *Start: 01/01/1995 | Last Modified: 01/20/2013*	11/1/2013
18	Exact duplicate claim/service (Use only with Group Code OA) Start: 01/01/1995 | Last Modified: 01/20/2013	1/20/2013
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 01/20/2013	11/1/2013
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA) Start: 02/28/1997 | Last Modified: 01/20/2013	1/20/2013

Deactivated Codes – CARC:

Code	Modified 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.) Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 11/01/2013	11/1/2013

Changes in RARC List Since CR8154

These are the changes in the RARC database since the last code update CR8154. The full RARC list must be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the Internet.

New – RARC:

Code	Current Narrative	Effective Date
N567	Not covered when considered preventative. *Start: 03/01/2013*	3/1/2013
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative. Start: 03/01/2013	3/1/2013
N569	Not covered when performed for the reported diagnosis. *Start: 03/01/2013*	3/1/2013
N570	Missing/incomplete/invalid credentialing data Start: 03/01/2013	3/1/2013
N571	Alert: Payment will be issued quarterly by another payer/contractor. *Start: 03/01/2013*	3/1/2013
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted. *Start: 03/01/2013*	3/1/2013
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor. *Start: 03/01/2013*	3/1/2013

Modified Codes – RARC:

Code	Current Narrative	Effective Date
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed. Start: 11/01/2012 | Last Modified: 03/01/2013	3/1/2013

Deactivated Codes – RARC: NONE

Additional Information

The official instruction, CR8281, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2686CP.pdf on the CMS website.

Standardizing the Standard – Operating Rules for Code Usage in Remittance Advice

MLN Matters® Number: MM8182
Related Change Request (CR) #: CR 8182
Related CR Release Date: February 8, 2013
Related CR Transmittal #: R1187OTN
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

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)

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;**
4. **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;**
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
6. 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, 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 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 carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1187OTN.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.

SELF-SERVICE TECHNOLOGY

IVR – Entering Beneficiary Name During Regular Business Hours

Entering a beneficiary name into the Noridian Interactive Voice Response (IVR) System during regular business hours, 6 a.m. – 6 p.m. CT, has changed.

Please use the single-key combination in the following format when keying a beneficiary's name on the keypad on your phone:

FULL FIRST NAME, FULL LAST NAME

For example, to key John Doe in the IVR using the single-key conversion during business hours, enter 5646363.

Please note this is for use during normal business hours 6 a.m. – 6 p.m. CT. Use the three-key combination in the following format during all other hours.

FIRST INITIAL ONLY, FULL LAST NAME

For example, to key John Doe in the IVR using the three-key conversion after hours, enter *51*31*63*32.

IVR information, including the single-key and three-key combination charts, is available at https://www.noridianmedicare.com/dme/contact/docs/ivr_at_a_glance.pdf [PDF].

PMD Prior Authorization Request Status Available in Endeavor

Effective February 20, 2013, suppliers can access the status of a Power Mobility Device (PMD) Prior Authorization Request (PAR) through Endeavor. Endeavor provides the Unique Tracking Number, receipt date, and the decision (pending, affirmative, or denied). Suppliers with access to eligibility and/or claim status portal functionality will automatically receive access to this new feature.

To inquire on PMD PAR status, enter the following information:

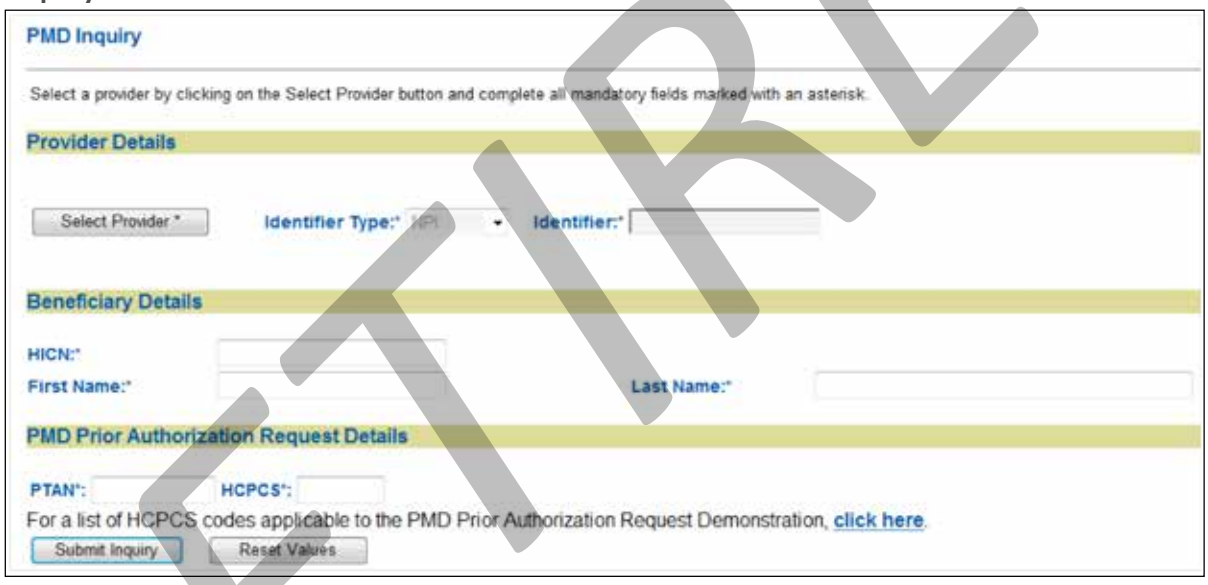
- National Provider Identifier (NPI)
- Beneficiary Medicare Number, first and last name
- Provider Transaction Access Number (PTAN)
- Requested HCPCS code

Note: PMD PARs may take up to two days after the date of the fax to display in Endeavor.

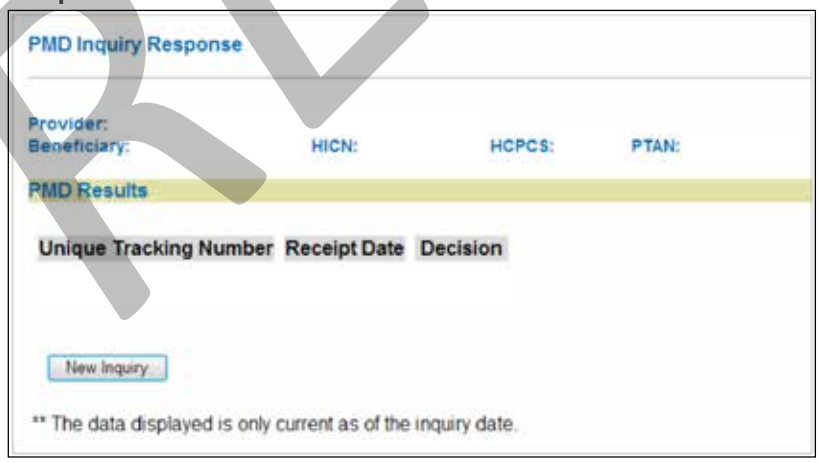
Endeavor only displays PMD PARs received on/after September 1, 2012.

For a list of applicable HCPCS codes, see the PMD PAR page, https://www.noridianmedicare.com/dme/prior_authorization_demonstration_pmd/index.html.

Inquiry Screen



Response Screen



For more information on Endeavor, go to https://www.noridianmedicare.com/dme/claims/endeavor.html.

SURGICAL DRESSINGS

Revised – Collagen Surgical Dressings – Coding Verification Review Requirement

Questions have recently come to the attention of the DME MACs and the PDAC concerning collagen dressings. The Local Coverage Determination Policy and Policy Article for Surgical Dressings contain the coverage criteria for surgical dressings as well as the Coding Guidelines for Surgical Dressings. The Surgical Dressings Policy Article states: *Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multi-component products may not be unbundled and billed as the separate components of the dressing.*

In the case of collagen dressings coded A6021, A6022, A6023 and A6024, the predominate component must be collagen.

Effective for claims with dates of service on or after June 1, 2013, the only products which may be billed to Medicare using code A6021, A6022, A6023 and A6024 are those for which a written coding verification has been made by the PDAC contractor and are listed on the Product Classification List in the Durable Medical Equipment Coding System (DMECS) maintained on the PDAC web site, https://www.dmepdac.com/dmecsapp/do/search. The DME MACs will be updating the Surgical Dressing Local Coverage Determination and Policy Article with this information.

All products currently listed on the Pricing, Data Analysis, and Coding (PDAC) contractor web site with HCPCS codes A6021, A6022, A6023 and A6024 will be end dated effective June 1, 2013, with the exception of the predicate product and a product recently reviewed by CMS' Alpha Numeric Workgroup. Manufacturers will be required to submit a new coding verification application to the PDAC for review and assignment of the correct code for products currently coded as A6021, A6022, A6023 and A6024.

Products which have not received coding verification review from the PDAC must be billed with code A9270.

The PDAC coding verification application required for these products is the Surgical Dressings application. This application is located on the PDAC website, https://www.dmepdac.com/review/apps_check.html.

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

TENS

DME on Demand – TENS

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

This session will include:

- Acronyms and Definitions
- Coverage Criteria
- Payment Rules
- Coding Guidelines
- Documentation
- Resources and Reminders

Viewing Presentation

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

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

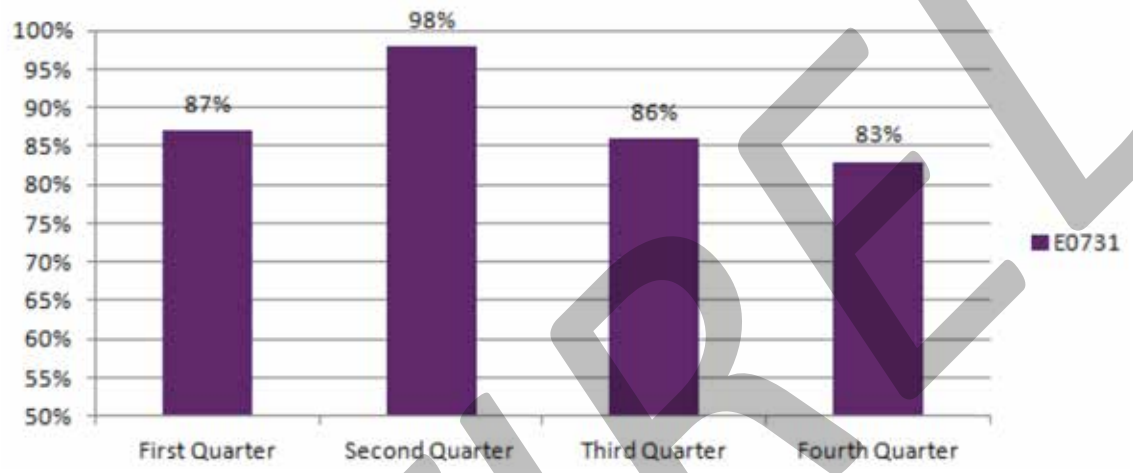
Fourth Quarter Results of Widespread Prepayment Review of Claims for Conductive Garment for Delivery of TENS or NMES (HCPCS E0731)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0731. The fourth quarter edit effectiveness results from January 2013 through April 2013 are as follows:

The E0731 review involved 163 claims of which 128 were denied. This resulted in an overall error rate of 83%.

Historical Data of the Error Rate for E0731 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 40% of E0731 claims received a denial as the documentation requested 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.

- 16% of E0731 claims received a denial as 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; and
  2. One of the medical indications outlined below is met:

  a. 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; or

  b. 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; or

  c. The patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or

  d. The patient requires electrical stimulation beneath a cast to treat chronic intractable pain.

- 14% of E0731 claims received a denial as the documentation provided does not support indication for garment during trial period.

  Per LCD L11495, A conductive garment is not covered for use with a TENS device during the trial period unless:

  - The beneficiary has a documented skin problem prior to the start of the trial period; and
  - The TENS is reasonable and necessary for the beneficiary.

If the criteria above are not met for E0731, it will be denied as not reasonable and necessary.

- 9% of E0731 claims received a denial as 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)

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 Local Coverage Determination (LCD) L11495 and Policy Article A37074.

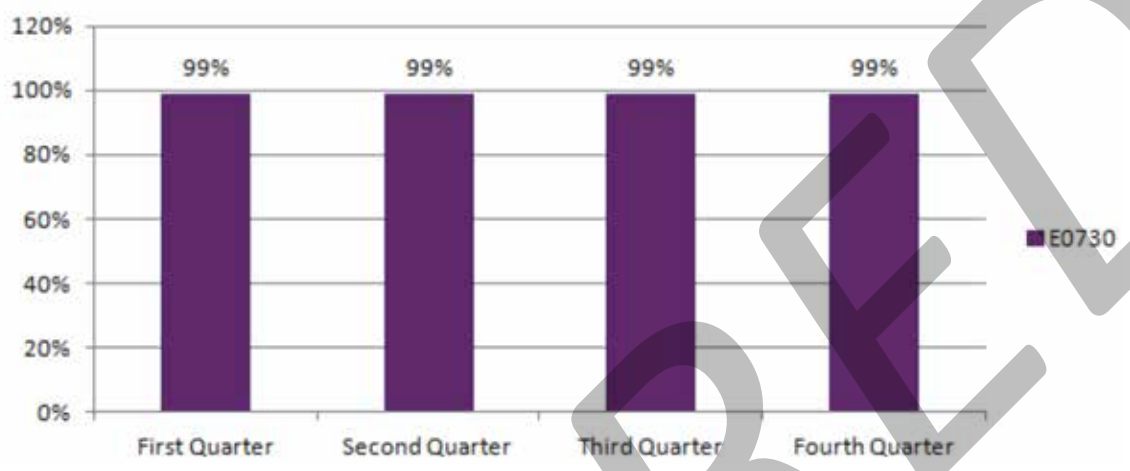
Noridian provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train/.

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

Fourth 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 the HCPCS code E0730. The fourth quarter edit effectiveness results from January 2013 through April 2013 are as follows:



The E0730 review involved 86 claims of which 83 were denied. This resulted in an overall error rate of 99%.

Historical Data of the Error Rate for E0730 Review

Primary Documentation Errors that Resulted in Denial of Claims

- 29% of E0730 claims received a denial as the documentation requested 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.

- 18% of E0730 claims received a denial as 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.

- 12% of E0730 claims received a denial as the documentation provided did not support the trial period criteria.

  Per LCD L11495, When used for the treatment of chronic, intractable pain described in section II, the TENS unit must be used by the beneficiary on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

- 10% of E0730 claims received a denial as the documentation provided did not support chronic pain criteria.

  Per LCD L11495, 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 Transcutaneous Electrical Nerve Stimulators Local Coverage Determination (LCD) L11495 and Policy Article A37074.

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

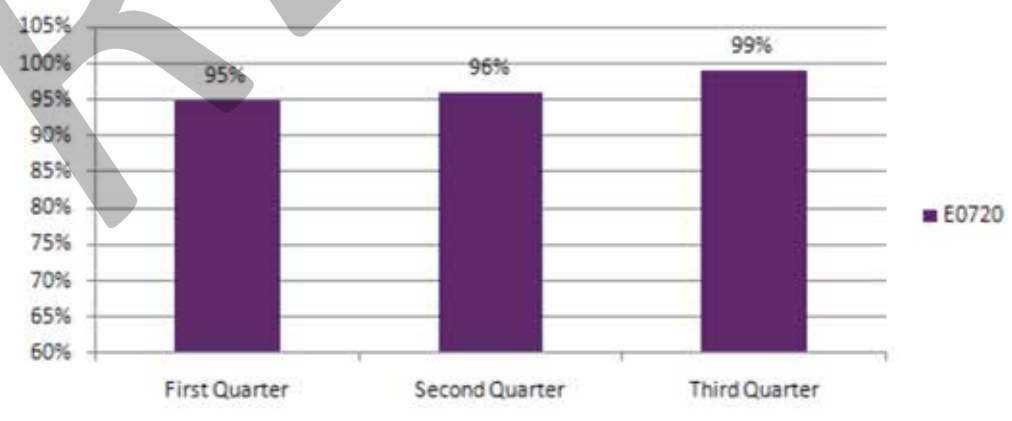
Third Quarter Results of Widespread Prepayment Review of Claims for TENS 2-LEAD (HCPCS E0720)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0720. The third quarter edit effectiveness results from November 2012 through February 2013 are as follows:

The E0720 review involved 109 claims of which 108 were denied. This resulted in an overall error rate of 99%.

Historical Data of the Error Rate for the E0720 Review



Primary Documentation Errors that Resulted in Denial of Claims

22% of E0720 claims received a denial as there was no documentation or the documentation provided did not support the trial criteria.

Per LCD L11495, when used for the treatment of chronic, intractable pain described in section II, the TENS unit must be used by the beneficiary on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the Transcutaneous Electrical Nerve Stimulators (TENS) unit in modulating the pain. For coverage of a purchase, the physician must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

12% of E0720 claims received a denial as there was no documentation or the documentation provided did 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.

11% of E0720 claims received a denial as there was no documentation or the documentation did not support chronic pain criteria.

Per LCD L11495, 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. 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.

8% of E0720 claims received a denial as there was no documentation or the documentation did not support that pain was present for 3 months.

Per LCD L11495, 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.

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 Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074

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

First Quarter 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 codes L7900. The first quarter edit effectiveness results from November 2012 through February 2013 are as follows:

The L7900 review involved 90 claims of which 65 were denied. This resulted in an overall error rate of 72%.

Primary Documentation Errors that Resulted in Denial of Claims

30% of L7900 claims received a denial as documentation submitted did not support medical necessity for the item ordered.

The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by Medicare, the patient'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 patient's diagnosis and other pertinent information including, but not limited to, duration of the patient'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 patient'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)."

13% of L7900 claims received a denial as proof of delivery (POD) was invalid.

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.

12% of L7900 claims received a denial as no order received.

The supplier for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is required to keep on file a physician prescription (order). A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary. The treating physician must sign and date the detailed written order.

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

10% of L7900 claims received a denial as no POD was submitted.

Suppliers are required to maintain proof of delivery documentation in their files. Proof of delivery documentation must be available to the DME MAC, DME PSC, and ZPIC 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 do not provide documentation to support their services may be referred to the OIG for imposition of CMPs or Administrative Sanctions.

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 National Coverage Determination for Diagnosis and Treatment of Impotence 230.4, CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 5 and the Supplier Manual Chapter 3.

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

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES