DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

March 2013 | Issue No. 38

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 a.m. – 8 p.m. 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	8am-6pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8am-4pm 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
NAS Email Addresses		
NAS DME Customer Service		dme@noridian.com
Reopenings and Redeterminations		dmeredeterminations@noridian.com
NAS DME Endeavor		dmeendeavor@noridian.com
Mailing Addresses		
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727		**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737		**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32231 -4013
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728		**DME Recovery Auditor Overpayments** Noridian Administrative Services 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

2013 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

The NAS 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 NAS 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	March 8	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	March 15	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	March 22	9:30 a.m. – 12 p.m. CT
Good Friday	March 29	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	April 12	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	April 19	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	April 26	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 10	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	May 17	9:30 a.m. – 12 p.m. CT
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
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 NAS Telephone Reopening Team will be closed for the entire day (8 a.m. through 4 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
Off-the-Phone Training	March 1	8 – 10 a.m. CT
Good Friday	March 29	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	April 5	8 – 10 a.m. CT
Off-the-Phone Training	May 3	8 – 10 a.m. CT
Memorial Day	May 27	Entire Day Closed 8 a.m. – 4 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 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 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 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 p.m. CT

2013 Update for DMEPOS Fee Schedule

MLN Matters® Number: MM8133 Revised
Related Change Request (CR) #: CR 8133
Related CR Release Date: January 11, 2013
Related CR Transmittal #: R2632CP
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Note: This article was revised on January 14, 2013, to reflect the revised CR8133 issued on January 11. The CR release date, transmittal number, and Web address were revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), or Regional Home Health Intermediaries (RHHIs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8133 to advise providers of the Calendar Year (CY) 2013 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Be sure your staffs are aware of these updates.

Background and Key Points of CR8133
The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

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

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

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted
The following new codes are effective as of January 1, 2013:

- A4435 in the ostomy, tracheostomy, and urological supplies (OS) payment category;
- E0670 and E2378 in the inexpensive/routinely purchased (IN) payment category;
- L5859, L7902 and L8605 in the prosthetics and orthotics (PO) payment category; and
- V5281 – V5290 (67).

The fee schedule amounts for codes E2378, L5859, L7902 will be established as part of the July 2013 DMEPOS Fee Schedule Update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2013, through June 30, 2013. The new codes are not to be used for billing purposes until they are effective on January 1, 2013.

For gap-filling purposes, the 2012 deflation factors by payment category are listed in the following table:

Factor	Category
0.477	Oxygen
0.480	Capped Rental
0.482	Prosthetics and Orthotics
0.611	Surgical Dressings
0.665	Parenteral and Enteral Nutrition

Specific Coding and Pricing Issues

1. The fee schedule amounts for shoe modification codes A5503 through A5507 are adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2013, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 are weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2011. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2013.
2. Effective January 1, 2013, new code L8605 Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ML is being added to the HCPCS code set. This code falls under the claims processing jurisdiction of local carriers rather than the DME MACs. Fee schedule amounts for this code are added as part of this update.

CY2013 Fee Schedule Update Factor

For CY 2013, the update factor of 0.8 percent is applied to the applicable CY 2012 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2013 by the percentage increase in the Consumer Price Index (CPI) for all Urban (U) consumers (United States city average), CPI-U, for the 12-month period ending with June of 2012, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP).

The MFP adjustment is 0.9 percent and the CPI-U percentage increase is 1.7 percent. Thus, the 1.7 percentage increase in the CPI-U is reduced by the 0.9 percent MFP adjustment resulting in a net increase of 0.8 percent for the 2013 MFP-adjusted update factor.

2013 Update to Labor Payment Rates

2013 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.7 percent effective for dates of service on or after January 1, 2013, through December 31, 2013, and those rates are as follows:

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
AK	$26.92	$30.67	$36.08	**NJ**	19.28	21.28	28.91
AL	14.29	21.30	28.91	**NM**	14.29	21.30	28.91
AR	14.29	21.30	28.91	**NV**	22.77	21.28	39.41
AZ	17.67	21.28	35.57	**NY**	26.32	21.30	28.91
CA	21.93	34.96	40.75	**OH**	14.29	21.28	28.91
CO	14.29	21.30	28.91	**OK**	14.29	21.30	28.91
CT	23.87	21.77	28.91	**OR**	14.29	21.28	41.57
DC	14.29	21.28	28.91	**PA**	15.34	21.91	28.91
DE	26.32	21.28	28.91	**PR**	14.29	21.30	28.91
FL	14.29	21.30	28.91	**RI**	17.03	21.93	28.91
GA	14.29	21.30	28.91	**SC**	14.29	21.30	28.91
HI	17.67	30.67	36.08	**SD**	15.97	21.28	38.65
IA	14.29	21.28	34.61	**TN**	14.29	21.30	28.91
ID	14.29	21.28	28.91	**TX**	14.29	21.30	28.91
IL	14.29	21.28	28.91	**UT**	14.33	21.28	45.02
IN	14.29	21.28	28.91	**VA**	14.29	21.28	28.91

KS	14.29	21.28	36.08	**VI**	14.29	21.30	28.91
KY	14.29	27.27	36.97	**VT**	15.34	21.28	28.91
LA	14.29	21.30	28.91	**WA**	22.77	31.21	37.07
MA	23.87	21.28	28.91	**WI**	14.29	21.28	28.91
MD	14.29	21.28	28.91	**WV**	14.29	21.28	28.91
ME	23.87	21.28	28.91	**WY**	19.92	28.38	40.31
MI	14.29	21.28	28.91				
MN	14.29	21.28	28.91				
MO	14.29	21.28	28.91				
MS	14.29	21.30	28.91				
MT	14.29	21.28	36.08				
NC	14.29	21.30	28.91				
ND	17.81	30.61	36.08				
NE	14.29	21.28	40.31				
NH	15.34	21.28	28.91				

2013 National Monthly Payment Amounts for Stationary Oxygen Equipment
CR8133 implements the 2013 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2013. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the payment class for Oxygen Generating Portable Equipment (OGPE).

The updated 2013 monthly payment amount of $177.36 includes the 0.8 percent update factor for the 2013 DMEPOS fee schedule.

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

2013 Maintenance and Servicing Payment for Certain Oxygen Equipment
CR8133 also updates the 2013 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in MLN Matters® Articles, MM6792, which is at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990, which is at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

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

Per 42 CFR section 414.210(5) (iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2012 maintenance and servicing fee is adjusted by the 0.8 percent MFP-adjusted covered item update factor to yield CY 2013 maintenance and servicing fee of $68.05 for oxygen concentrators and transfilling equipment.

Additional Information
You can find the official instruction, CR8133, issued to your FI, carrier, RHHI, or A/B MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2632CP.pdf on the CMS website.

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

CMS e-News

November 15, 2012: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-15-e-News.pdf

National Provider Calls

- Physician Quality Reporting System and Electronic Prescribing Incentive Program - Register Now
- CMS Plans for the Initial Implementation in 2015 of the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule - Registration Now Open
- Transcript and Audio Now Available From October 24 Call on In-depth Overview of Stage 2 Clinical Quality Measures for the Medicare and Medicaid EHR Incentive Programs for Eligible Professionals

Announcements and Reminders

- November is Lung Cancer Awareness Month and November 15 is the Great American Smokeout
- Seasonal Influenza Educational Resources for Providers
- CMS Celebrates One-Year Anniversary of Electronic Submission of Medical Documentation System
- Data Collection Period for the Hospice Quality Reporting Program to Transition to Calendar Year Beginning January 2013
- CMS to Release New ST PEPPER in November
- CMS Releases Stage 2 Meaningful Use Specification Sheets with Details on Each Measure
- Look at the CMS 2014 CQM Page and New CQM Resources
- Communicating with Your Payers About ICD-10

MLN Educational Products Update

- "Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients" MLN Matters® Article - Released
- "Alert Concerning Impacts Arising from Having Non-Compliant Physical or Practice Address Information on File with Medicare" MLN Matters® Article - Released
- "Hurricane Sandy and Medicare Disaster Related Claims" MLN Matters® Article - Released
- "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet - Revised
- "Medicare Disproportionate Share Hospital" Fact Sheet - Revised
- "Cardiovascular Disease Services" Booklet - Released
- "Screening Pap Tests" Booklet - Released
- "Providing the Annual Wellness Visit" Booklet - Released
- "Basic Medicare Information for Providers and Suppliers" Guide (previously titled "Medicare Physician Guide") - Revised

November 29, 2012: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2012-11-29Message.html

National Provider Calls

- Preparing for Therapy Functional Reporting Implementation in CY 2013 - Registration Now Open
- PQRS and eRx Incentive Program - Save the Date

Announcements and Reminders

- Quick Reference Tool for Those Who Refer Medicare Patients for DMEPOS
- World AIDS Day is December 1
- National Influenza Vaccination Week is December 2-8
- CY 2013 Home Health Prospective Payment System Final Rule - Update on the Effective Dates for Therapy Provisions

FYI CONT'D

- November 30 is the Last Day for Eligible Hospitals and Critical Access Hospitals to Register and Attest for an Incentive Payment in FY 2012
- CMS Distributes Free Hand in Hand Toolkit to Every Nursing Home in the Nation
- ICD-10 Version of FY 2013 MS-DRG Files Now Available

MLN Educational Products Update

- "Importance of Preparing/Maintaining Legible Medical Records" MLN Matters® Article - Released
- "Medicare DMEPOS Competitive Bidding Program: Quick Reference Article" MLN Matters® Article - Released
- New MLN Educational Web Guides Fast Fact

December 6, 2012:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-12-06-e-News.pdf

National Provider Calls

- Preparing for Therapy Functional Reporting Implementation in CY 2013 - Register Now
- PQRS and eRx Incentive Program - Registration Now Open
- Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare DSH Payments - Save the Date
- Meaningful Use: Stage 1 and Stage 2 - Save the Date

Announcements and Reminders

- Flu Season is Here
- What are Quality and Resource Use Reports and the Value-Based Payment Modifier, and How Do They Affect Physicians?
- Informal Review for the 2013 eRx Incentive Program Payment Adjustment Begins December 10
- New Information on Hospital Outpatient Payments Available on the CMS Website
- Hospice Quality Reporting Program Website Updated
- Direct GME and IME Slots Awarded under Section 5506 of the Affordable Care Act
- Verify Your Registration with PECOS, the MAC, and the EHR Registration System
- Planning for ICD-10: Working with Clearinghouses and Billing Services

MLN Educational Products Update

- "Implementation of Provider Enrollment Provisions in CMS-6028-FC" MLN Matters® Article - Revised
- "Further Details on the Revalidation of Provider Enrollment Information" MLN Matters® Special Edition Article - Revised
- "Federally Qualified Health Center" Fact Sheet - Revised
- "Swing Bed Services" Fact Sheet - Revised
- "Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Standards" Web-Based Training Course - Reminder
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists
- Submit Feedback on MLN Educational Products

December 13, 2012:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews121312.pdf

FYI CONT'D

National Provider Calls

- PQRS and eRx Incentive Program - Register Now
- Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare DSH Payments - Registration Opening Soon
- Meaningful Use: Stage 1 and Stage 2 - Save the Date

Announcements and Reminders

- CMS Distributes Free Hand in Hand Toolkit to Every Nursing Home in the Nation
- CMS to Release a Comparative Billing Report on Home Health Services - Target Release January 23
- Hospice Quality Reporting Program Data Submission WebEx is Available
- Future Hospice Data Collection - Public Comments Accepted Through January 31
- Review the Changes to the EHR Incentive Programs for Hospitals Included in New Interim Final Rule with Comment
- Get Paid for 2012: Stay Informed of Key Program Deadlines for the EHR Incentive Programs
- Where to Find ICD-10 Information

Claims, Pricer, and Code Updates

- January 2013 Average Sales Price Files Now Available

MLN Educational Products Update

- "HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" MLN Matters® Article - Released
- "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" MLN Matters® Article - Revised
- "Phase 2 of Ordering/Referring Requirement" MLN Matters® Article - Revised
- "NPI: Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees" Fact Sheet - Revised
- "The National Provider Identifier (NPI): What You Need to Know" Booklet - Revised
- "Mass Immunizers and Roster Billing" Fact Sheet - Revised

December 20, 2012: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews-12202012.pdf edition of the CMS e-News includes the following information:

National Provider Calls

- Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare DSH Payments - Registration Now Open
- Meaningful Use: Stage 1 and Stage 2 - Save the Date
- Announcements and Reminders
- Flu Season is Here
- Provider Enrollment Application Fee Amount for Calendar Year 2013
- Webinar Available on CMS National Partnership to Improve Dementia Care in Nursing Homes
- Health Professional Shortage Area Bonus Payment Reminder

Claims, Pricer, and Code Updates

- CMS Correcting Error in Processing of Claims by Pathologists and Independent Laboratories for Professional Component of Certain Physician Pathology Services
- Adjustments for ESRD Claims with Outlier Payments

FYI CONT'D

MLN Educational Products Update

- "Prescription Drug Monitoring Programs: A Resource to Help Address Prescription Drug Abuse and Diversion" MLN Matters® Article - Released
- "Sole Community Hospital" Fact Sheet - Revised
- "Rural Health Clinic" Fact Sheet - Revised
- "Discharge Planning" Booklet - Released
- "Skilled Nursing Facility Prospective Payment System" Fact Sheet - Revised
- New MLN Provider Compliance Fast Fact

January 4, 2013:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-04-Enews.pdf

National Provider Calls

- Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare DSH Payments - Last Chance to Register
- Meaningful Use: Stage 1 and Stage 2 - Registration Now Open
- CMS National Partnership to Improve Dementia Care in Nursing Homes - Registration Now Open

Announcements and Reminders

- 2013 Resolutions – Help Your Patients Live a Healthier Life in 2013
- Flu Season is Here
- CMS Announces 90-Day Period of Enforcement Discretion for Compliance with Eligibility and Claim Status Operating Rules
- Simple Steps to Improve Clinical Documentation for ICD-10
- Listening Sessions on End-to-End Testing for ICD-10 Slated for January

Claims, Pricer, and Code Updates

- Revised October 2012 Outpatient Prospective Payment System Pricer File Update
- January 2013 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products Update

- New MLN Educational Web Guides Fast Fact

January 17, 2013:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-17-eNews.pdf

National Provider Calls

- 2012 PQRS and eRx Incentive Program Data Submission - Registration Now Open
- CMS National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Video Slideshow Presentation from October 25 Call on Preparing Physicians for ICD-10 Implementation Now Available

Announcements and Reminders

- Flu Season is Here
- More Doctors, Hospitals Partner to Coordinate Care for People with Medicare
- Reminder: Hospice Quality Reporting Program Structural Measure Data Submission Deadline is January 31
- 2013 Medicare Occupational Mix Survey - Proposed Collection
- 2013 Self-Nomination/Registration for PQRS Group Practice Reporting Option - Updated
- CMS Created a New Tipsheet to Help Specialists Meet Meaningful Use
- ICD-10: Listening Sessions for End-to-End Testing
- Planning Your ICD-10 Transition Activities for 2013

FYI CONT'D

MLN Educational Products Update

- "Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record" Fact Sheet - Reminder
- "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet - Reminder
- "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet - Reminder
- "Intensive Behavioral Therapy (IBT) for Obesity" Booklet - Reminder
- New MLN Provider Compliance Fast Fact
- Updated MLN Matters® Search Indices

January 24, 2013:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-24-e-News.pdf

National Provider Calls

- CMS National Partnership to Improve Dementia Care in Nursing Homes - Last Chance to Register
- January 8 DSH Written Transcript and Audio Recording Now Available

Other Calls, Meetings, and Events

- CMS to Host Elder Maltreatment & Care Symposium - Register Now

Announcements and Reminders

- Don't Miss DMEPOS Competitive Bidding Webinars for All Provider Types Next Week
- January 31 Deadline for Attestation and Submission of Structural Measure Data for the Hospice Quality Reporting Program
- EHR Incentive Programs: Several Changes to Stage 1 Meaningful Use Measures Begin This Year
- Insulin Pen Safety – One Insulin Pen, One Person

Claims, Pricer, and Code Updates

- CY 2013 Outpatient Prospective Payment System Pricer File Update
- Quarterly Provider Specific Files for the Prospective Payment System are Now Available

MLN Educational Products Update

- "Hospice Quality Data Reporting Reminders" MLN Matters® Article - Released
- "End-Stage Renal Disease Prospective Payment System" Fact Sheet - Revised
- New MLN Educational Web Guides Fast Fact

January 31, 2013:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/Enews-2013-01-31.pdf

Other Calls, Meetings, and Events

- Materials from the January 24 Special ODF on Quality Improvement Organizations - Comments due February 8

Announcements and Reminders

- New Adult Vaccine Finder
- 2012-2013 Seasonal Flu Update: Seniors among Groups Hardest Hit by Flu this Season
- Direct GME and IME Slots Awarded under Round 3 of Section 5506 of the Affordable Care Act
- CMS Has Added New and Updated EHR Incentive Programs FAQs to the CMS FAQ Website
- Providers Should Review the Use of Insulin Pens in Health Care Facilities

FYI CONT'D

MLN Educational Products Update

- "Text-Only Rural Health" Fact Sheets - Released
- "Hospital Outpatient Prospective Payment System" Fact Sheet - Revised
- "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet - Revised
- "End-Stage Renal Disease Prospective Payment System" Fact Sheet - Reminder
- "World of Medicare" Web-Based Training Course Series
- "Medicaid Program Integrity: Safeguarding Your Medical Identity" Educational Products - Reminder
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Podcast - Reminder

February 7, 2013:
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-07-Enews.pdf

National Provider Calls

- How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment - Registration Now Open
- End-Stage Renal Disease Quality Incentive Program - Payment Year 2015 Final Rule - Registration Now Open

Other Calls, Meetings, and Events

- ICD-9-CM Coordination and Maintenance Committee Meeting - Registration Now Open

Announcements and Reminders

- Preventing Heart Disease and Increasing Awareness of its Affects
- Flu Season Isn't Over - Continue to Recommend Vaccination
- Affordable Care Act "Sunshine" Rule Increases Transparency in Health Care
- Reforms of Regulatory Requirements to Save Health Care Providers $676 Million Annually
- CMS Announces New Initiative to Improve End-Stage Renal Disease Care
- 2013 ICD-10-CM Present on Admission Exempt Code List Now Available
- Hospice Quality Reporting Program Structural Measure Deadline has Passed: NQF #0209 Deadline is April 1
- DMEPOS Competitive Bidding - Fact Sheet Revised
- Diabetic Testing Supplies Provisions of the American Taxpayer Relief Act of 2012
- February 28th is the Last Day for EPs to Submit Medicare Part B Claims for the EHR Incentive Programs

MLN Educational Products Update

- "Medicare Quarterly Provider Compliance Newsletter *Volume 3, Issue 2+" Educational Tool - Released
- "Long Term Care Hospital Prospective Payment System" Fact Sheets - Revised
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet - Reminder
- "Physician Quality Reporting System: Physician Compare" Fact Sheet

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."

President Obama Signs the American Taxpayer Relief Act of 2012

New Law Includes Physician Update Fix through December 2013

On Wednesday, January 2, 2013, President Obama signed into law the **American Taxpayer Relief Act of 2012**. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2013. The new law provides for a zero percent update for such services through December 31, 2013. This provision guarantees seniors have continued access to their doctors by fixing the Sustainable Growth Rate (SGR) through the end of 2013. President Obama remains committed to a permanent solution to eliminating the SGR reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.

The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies (with January 1, 2013, or October 1, 2012, effective dates) have been extended. We also have included Medicare billing and claims processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 601 – Medicare Physician Payment Update – As indicated above, the new law provides for a zero percent update for claims with dates of service on or after January 1, 2013, through December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is currently revising the 2013 Medicare Physician Fee Schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2013 conversion factor is $34.0230.

In order to allow sufficient time to develop, test, and implement the revised MPFS, Medicare claims administration contractors may hold MPFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). We expect these claims to be released into processing no later than January 16, 2013. The claim hold should have minimal impact on physician/practitioner cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected. Medicare claims administration contractors will be posting the MPFS payment rates on their websites no later than January 23, 2013.

The 2013 Annual Participation Enrollment Program allowed eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2012. Given the new legislation, CMS is extending the 2013 annual participation enrollment period through February 15, 2013. Therefore, participation elections and withdrawals must be post-marked on and before February 15, 2013. The effective date for any participation status changes elected by providers during the extension remains January 1, 2013.

Section 602 - Extension of Medicare Physician Work Geographic Adjustment Floor - The 2012 1.0 floor on the physician work geographic practice cost index is extended through December 31, 2013. As with the physician payment update, this extension will be reflected in the revised 2013 MPFS.

Section 603 - Extension Related to Payments for Medicare Outpatient Therapy Services - Section 603 extends the exceptions process for outpatient therapy caps through December 31, 2013. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2013. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD), and counts outpatient therapy services furnished in a Critical Access Hospital towards the cap and threshold. Additional information about the exception process for therapy services may be found in the Medicare Claims Processing Manual, Pub.100-04, Chapter 5, Section 10.3: http://www.cms.gov/manuals/downloads/clm104c05.pdf.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2013. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is $1,900. There is a separate cap for occupational therapy services which is $1,900 for 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 603 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013 through December 31, 2013, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 604 - Extension of Ambulance Add-On Payments - Section 604 extends the following three Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through December 31, 2013; (2) the provision relating to air ambulance services that continues to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, is extended through June 30, 2013; and (3) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus) is extended through December 31, 2013.

CMS is currently revising the 2013 Medicare Ambulance Fee Schedule (MAFS) to reflect the new law's requirements. In order to allow sufficient time to develop, test, and implement the revised MAFS, Medicare claims administration contractors may hold MAFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). We expect these claims to be released into processing no later than January 16, 2013. The claim hold should have minimal impact on supplier cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected.

Suppliers of ambulance services affected by these provisions may continue billing as usual.

Section 605 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals - The Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through September 30, 2013, retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Section 606 - Extension of the Medicare-Dependent Hospital (MDH) Program - The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Be on the alert for more information about the American Taxpayer Relief Act of 2012.

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.

Redesign of the Medicare Summary Notice – Final Implementation – And Major Update to Chapter 21 of Claims Process Manual

MLN Matters® Number: MM7676
Related Change Request (CR) #: 7676
Related CR Release Date: August 21, 2012
Related CR Transmittal #: R2522CP
Effective Date: January 3, 2013
Implementation Date: January 3, 2013

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B/ MACs), Regional Home Health Intermediaries (RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
The content and format of the Medicare Summary Notice (MSN) are redesigned, effective January 3, 2013.

In Change Request (CR) 7676, CMS announces that (effective January 3, 2013) the content and format of the MSN have been redesigned. It also announces relevant manual changes that Medicare contractors will use to implement the newly designed document. Note that MACs will begin phasing the new MSN beginning on January 3, 2013.

Background
Section 1806(a) of the Social Security Act (the Act) requires the Centers for Medicare & Medicaid Services (CMS) to provide a Part A, Part B, and/or Durable Medical Equipment (DME) Medicare Summary Notice (MSN) to each Medicare beneficiary. The MSN content and format are impacted by statute, legislation, and court decisions including:

- The Plain Writing Act of 2010, which requires all government communications to be written in plain language that is easily understood by the target audience;
- Sections 1806(b), 1816(j), 1842(h)(7), 1848(g), 1869(a)(4), and 1869(a)(4)(C) of the Act;
- 42 C.F.R. Section 405.921;
- Section 925 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173); and
- Court decisions Gray Panthers v. Schweiker, 652 F. 2d 146, 168 (D.C. Cir. 1980); David v. Heckler, 591 F.Supp. 1033 (E.D.N.Y 1984); Vorster v. Bowen, 709 F.Supp 934 (C.D. Cal. 1989); and Connecticut Department of Social Services v. Leavitt , 428 F.3d 138 (2d Cir. 2005).

CR7676, from which this article is taken, announces that CMS has undertaken a redesign of the MSN, in order to: 1) make the document current and consistent with all applicable statutes and laws, and 2) to render it more easily and widely understood by the beneficiary population that it serves.

In addition, CR7676 announces that of the "Medicare Claims Processing Manual" Chapter 21 (Medicare Summary Notices), Sections 10.3-31 (MSN Redesign) has been updated to reflect the new MSN designs. This update is effective with the final implementation of the new designs on January 3, 2013, and will be used to provide guidance on the implementation of these new MSN designs.

Additional Information
You can find the official instruction, CR7676, issued to your carrier, FI, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2522CP.pdf on the CMS website. You will find the updated "Medicare Claims Processing Manual" Chapter 21 (Medicare Summary Notices), Sections 10.3-31 (MSN Redesign), and including all of the new (and final) MSN designs as attachments to that CR.

FYI CONT'D

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate NAS' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from CMS. Whenever NAS 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. NAS 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 NAS bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
1	What is Medicare	Updated deductible fee for 2013	01/15/13
6	Mandatory Claim Filing	Added EY modifier information	01/15/13
6	Time Limit for Filing Claims	Updated date table	01/15/13
6	Consolidated Billing	Added ESRD information	01/15/13
6	Consolidated Billing	Removed EPO and dialysis	01/15/13
Appendix	Resources	Added PMD Demo IVR Reason	01/15/13
12	Pricing	Fee schedule amounts are updated in January and July.	11/09/12

APPEALS

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 p.m. CT (Closed 11:45 a.m. – 12:30 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, NAS 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 NAS 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.

2013 DMEPOS HCPCS Code Jurisdiction List

MLN Matters® Number: MM8164
Related Change Request (CR) #: CR 8164
Related CR Release Date: January 18, 2013
Related CR Transmittal #: R2637CP
Effective Date: January 1, 2013
Implementation Date: February 19, 2013

Provider Types Affected
This MLN Matters® Article is intended for suppliers submitting claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs), carriers, and Part B MACs) for DMEPOS services provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8164 to notify suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, carrier, or B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS codes appearing on the spreadsheet. The spreadsheet for the 2013 Jurisdiction List is an Excel® spreadsheet and available under the Coding Category at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html on the CMS website.

Additional Information
You can find the official instruction, CR8164, issued to your Medicare Carrier, DME MAC, or B MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2637CP.pdf on the CMS website. The Excel® spreadsheet for the 2013 Jurisdiction List is also attached to CR8164.

New Place of Service Code for Place of Employment/Worksite

MLN Matters® Number: MM8125
Related Change Request (CR) #: CR 8125
Related CR Release Date: November 30, 2012
Related CR Transmittal #: R2602CP
Effective Date: April 1, 2013
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 (Medicare carriers, Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for occupational-related medical, therapeutic, or rehabilitative services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 8125, from which this article is taken, updates the current Place of Service (POS) code set to add a new code: 18 – Place of Employment/Worksite.

Background
CR8125, from which this article is taken, updates the current Medicare POS code set to add a new code: 18 – Place of Employment/Worksite; described as: "a location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual."

The Centers for Medicare & Medicaid Services (CMS) is establishing this POS code because:

1. Industry entities (other than Medicare) have identified a need to establish the delivery of occupational-related medical and rehabilitation services in the work place in order to: A) reduce employee time lost from work; and B) enable therapists to evaluate the work environment and provide rehabilitation services that are focused on returning the individual to their pre-injury state in a way that maximizes function in the workplace environment and reduces employee time lost.

2. As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with its standards and their implementation guides that are adopted by regulation. Specifically, the currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12 837 (Professional Health Care Claim) standards requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that CMS maintains.

Therefore, while it has not identified an inherent need for this new code; as a payer, Medicare must be able to recognize any code from the POS code set that appears on the HIPAA standard claim transaction.

Additional Information
The official instruction, CR8125, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2602CP.pdf on the CMS website.

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2013

MLN Matters® Number: MM8052
Related Change Request (CR) #: CR 8052
Related CR Release Date: December 7, 2012
Related CR Transmittal #: R81GI
Effective Date: January 1, 2013
Implementation Date: January 7, 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) 8052 which informs Medicare contractors about the changes needed to update the claims processing system with the new Calendar Year (CY) 2013 Medicare rates. 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.

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

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

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

BILLING CONT'D

The following deductible and coinsurance rates apply for 2013.

- 2013 PART A - HOSPITAL INSURANCE (HI)
  - Deductible - $1,184.00
  - Coinsurance:
  - $296.00 a day for 61st-90th day
  - $592.00 a day for 91st-150th day (lifetime reserve days)
  - $148.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
  - Base Premium (BP) - $441.00 per month
  - BP with 10% surcharge - $485.10 a month
  - BP with 45% reduction - $243.00 a month (for those who have 30-39 quarters of coverage)
  - BP with 45% reduction and 10% surcharge - $267.30 a month
- 2013 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)
  - Standard Premium - $104.90 a month
  - Deductible - $147.00 a year
  - Coinsurance - 20 percent

Additional Information
The official instruction, CR8052 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/R81GI.pdf on the CMS website.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

CERT CONT'D

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

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

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

COMPETITIVE BIDDING

CMS Announces DMEPOS Competitive Bidding Payment Amounts for the Round 2 and National Mail-Order Competitions

On January 30, 2013, CMS announced the single payment amounts for the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

For additional information:

- Press Release
- Fact Sheet
- CMS website

Medicare DMEPOS Competitive Bidding Program: Quick Reference Article

MLN Matters® Number: SE1244

Provider Types Affected
This MLN Matters® Special Edition Article is informational in nature. It is intended to be a quick reference tool for all health care professionals who order or refer patients for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) in a Competitive Bidding Area (CBA).

Background
The Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program (The Program) was successfully implemented in nine areas on January 1, 2011. Round 2 of The Program is targeted to go into effect in 91 Metropolitan Statistical Areas (MSAs) on July 1, 2013. Medicare will also be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

When a round of The Program becomes effective, beneficiaries with Original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. Referral agents located in CBAs who prescribe DMEPOS for Medicare beneficiaries or refer beneficiaries to specific suppliers should be aware of which suppliers in the area are contract suppliers. The Centers for Medicare & Medicaid Services (CMS) plans to announce the contract suppliers for Round 2 and the national mail order program in the spring of 2013.

About This Article
This article 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 Program. The information found at these sources will greatly assist referral agents in locating information that will assist them in obtaining DMEPOS items and services for Medicare beneficiaries. For purposes of The Program, referral agents include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, disability/disease-based organizations, and pharmacists who refer beneficiaries for services in a CBA.

COMPETITIVE BIDDING CONT'D

Referral agents play a critical role in helping beneficiaries select DMEPOS suppliers that can meet the beneficiaries' needs and meet the requirements of the program. A beneficiary's first contact with The Program may be at the point when he or she receives a prescription for a competitively bid item. If the beneficiary resides in a CBA or is visiting a CBA in which he or she needs to obtain a competitively bid item, he or she may need to be directed to a contract supplier.

Where Do I Go to Learn More About the Medicare DMEPOS Competitive Bidding Program?
The CMS webpage on The Program (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html) provides links to the latest news, press releases, announcements and fact sheets. A link to the Round 2/National Mail Order timeline can also be found on this webpage.

Partnering with CMS is a key to helping people with Medicare maximize their benefits. Beyond extending the reach of these important benefits to people who need them, a partnership helps you leverage resources by fostering relationships with other CMS partners, keeps you informed, and provides you with expert training, educational materials, tools such as this toolkit at http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html, research, and a connection to CMS' 10 regional offices, where you may access personalized local assistance.

E-Mail Updates for Referral Agents
In the coming months leading up to the start of The Program, CMS will send out more information that will be helpful for referral agents and guide them through the changes that the new program brings.

In light of the important role that referral agents serve, CMS has adopted the use of a new email update to better communicate the various aspects of The Program and to ensure that official information is released and received by referral agents as quickly as possible. CMS encourages all referral agents to sign up for this new email update to ensure they receive the most accurate and timely information regarding The Program.

To ensure you give Medicare patients correct DMEPOS information, sign up for the email updates for referral agents.

How Do I Know If a Medicare Beneficiary Resides in a Competitive Bidding Area?
The Competitive Bidding Implementation Contactor (CBIC) provides a tool at http://www.dmecompetitivebid.com to find a CBA on its website. To determine if a beneficiary resides in a CBA, click on the "Find a CBA" tab and enter the ZIP CODE of the beneficiary's permanent residence on file with the Social Security Administration (SSA).

The tool will indicate whether the ZIP CODE is within a CBA or not.

How Do I Find a Medicare Contract Supplier for a Medicare Beneficiary in a CBA?
The Medicare.gov website (http://www.medicare.gov/default.aspx) provides a Supplier Directory tool under the "Resource Locator" tab for finding a Medicare contract supplier to provide certain durable medical equipment in the Medicare DMEPOS Competitive Bidding Program where the beneficiary resides. Once the contract suppliers have been announced, the Supplier Directory tool will indicate whether the beneficiary is affected by the Medicare Competitive Bidding program based on the beneficiary's ZIP CODE and the particular DMEPOS needed.

Customer service representatives at 1-800-MEDICARE (1-800-633-4227) can also assist beneficiaries in finding a contract supplier. TTY users should call 1-877-486-2048.

How Do I Know What DMEPOS Items and Services Are Competitively Bid Items in the Program?
Product categories are groupings of related items that are used to treat a similar medical condition. A list of the product categories for Round 2 can be found by visiting http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Product_Categories_and_Items.html on the CMS website.

The CBIC provides a tool to identify specific items within a product category by Healthcare Common Procedure Coding System (HCPCS) code at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Product%20Categories on its website.

Implementation of the PWK (Paperwork) Segment for X12N Version 5010

MLN Matters® Number: MM7041 Revised
Related Change Request (CR) #: 7041
Related CR Release Date: April 20, 2011
Related CR Transmittal #: R874OTN
Effective Date for Providers: July 1, 2011
Implementation Date: July 5, 2011

Note: This article was updated on December 7, 2012, to reflect current Web addresses. This article was previously revised on April 21, 2011, to reflect a revised CR7041 issued on April 20, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR7041 have been revised. Also, a reference to MLN Matters® article SE1106 was added in the Additional Information section to give important reminders about the implementation of HIPAA 5010 and D.O., including Fee-For-Service implementation schedule and readiness assessments. All other information remains unchanged.

Provider Types Affected
This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment (DME) MACs, and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Provider Action Needed
This article is based on Change Request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background
Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key Points for Medicare Billers:

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at http:/www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/sharedsavingsprogram/index.html on the CMS website.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information
The official instruction (CR 7041) issued to your MAC and/or FI/carrier is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R874OTN.pdf on the CMS website.

You may also want to review MLN Matters® article MM7306 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7306.pdf on the CMS website.

You may also want to review MLN Matters® article SE1106 available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf for important reminders about the implementation of HIPAA 5010 and D.O., including Fee For Service implementation schedule and readiness assessments.

Importance of Preparing/Maintaining Legible Medical Records

MLN Matters® Number: SE1237

Provider Types Affected
This MLN Matters® Article Special Edition (SE) is intended for physicians and other providers who document treatment for Medicare beneficiaries and/or submit claims for Medicare Fee-For-Service (FFS) reimbursement.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is publishing this article to highlight the importance of legible documentation in avoiding claim denials. This SE1237 article is informational only and does not alter existing Medicare policy, and does not introduce new policy.

Background
Many claim denials occur because the providers or suppliers do not submit sufficient documentation to support the service or supply billed. Frequently, this documentation is insufficient to demonstrate medical necessity. In accordance with Section 1862(a)(1)(A) of the Social Security Act, CMS must deny an item or service if it is not reasonable and necessary.(See item 1 in the "References" section below.) When determining the medical necessity of the item or service billed, Medicare's review contractors must rely on the medical documentation submitted by the provider in support of a given claim. Therefore, legibility of clinical notes and other supporting documentation is critical to avoid Medicare FFS claim payment denials. (See item 2 in the "References" section below.)

Key Points

General Principles of Medical Record Documentation (See items 3,4,5 in the "References" section below. - Be Aware
The general principles of medical record documentation to support a service or supply billed for Medicare payment includes the following (as applicable to the specific setting/encounter):

1. Medical records should be complete and legible; and
2. Medical records should include the legible identity of the provider and the date of service

Amendments, Corrections and Delayed Entries in Medical Documentation (See item 6 in the "References" section below.)
Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles:

1. Clearly and permanently identify any amendments, corrections or addenda.
2. Clearly indicate the date and author of any amendments, corrections, or addenda.
3. Clearly identify all original content (do not delete).

Medicare Signature Requirements (See item 7 in the "References" section below.)
For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature.

- If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received). Signature attestations are not allowable for orders.

References

- See the testimony of Thursday, July 15, 2010 to the United States Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and Internet. "Preventing and Recovering Medicare Payment Errors" at http://www.hhs.gov/asl/testify/2010/07/t20100715a.html on the CMS website.
- See the CMS "Medicare Program Integrity Manual" Section 3.6.2.1 - Coverage Determinations at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf on the CMS website.
- See the "Medicare Benefit Policy Manual" Chapter 2, Section 30, at http://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Downloads/bp102c02.pdf on the CMS website.
- See Change Request (CR) 2520, Provider Education Article, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB03037.pdf on the CMS website.
- See the MLN Matters® Special Edition article, SE1027, entitles "Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1027.pdf on the CMS website.
- See the "Medicare Program Integrity Manual" Section 3.3.2.5 – Amendments, Corrections and Delayed Entries in Medical Documentation at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf on the CMS website.
- See the "Medicare Program Integrity Manual" Section 3.3.2.4 - Signature Requirements http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf on the CMS website.

Additional Information
For additional information and educational materials related to provider compliance, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website.

To review specific rules for signature guidelines for medical review purposes and language for E-Prescribing you may go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf on the CMS website.

Medicare Eligibility and Documentation Requirements for DMEPOS Items Obtained Prior to Medicare Eligibility

Once a beneficiary becomes Medicare eligible and is seeking payment for a DMEPOS item(s) obtained prior to their eligibility, all Medicare Fee-for-Service (FFS) payment and documentation rules are applicable to the DMEPOS item(s) on the date of service for the item(s).

Purchased Items (Including Supplies)
If, at the time of transition to Medicare, the beneficiary owns a DMEPOS item that can be purchased under the Medicare program, Medicare can pay for reasonable and necessary supplies and repairs to that item. At the time of replacement of that entire item, Medicare treats the claim as a new, initial claim (not as a replacement). Therefore, all coverage and documentation requirements must be met to justify reimbursement for the item. Refer to the applicable local coverage determination and related policy article for specific information about coverage, coding and documentation. For durable medical equipment, only certain items can be paid for on a purchase basis under the Medicare program. Medicare payment can only be made for necessary supplies and repairs of beneficiary-owned equipment that Medicare can purchase, which includes items classified under the Medicare program as inexpensive or routinely purchased items, complex rehabilitative power wheelchairs, or customized items uniquely constructed or substantially modified for a specific patient. This applies in all situations, including situations where the equipment is purchased prior to Medicare eligibility.

Rental Items
For rental items, i.e. the beneficiary does not own the item at the time of transition to Medicare: Medicare does not automatically assume payment for the item. Rental coverage by Medicare is treated as a new, initial claim (not as a replacement). Therefore, all coverage and documentation requirements must be met to justify reimbursement for the item. Refer to the applicable local coverage determination and related policy article for specific information about coverage, coding and documentation.

The disposition of the original item rests with the original payer, not Medicare. In addition to meeting Medicare's coverage requirements, Medicare requires that the Medicare-billed equipment be new or refurbished at the start of an initial rental.

All rented equipment must remain in good working order for the entire 5 year reasonable useful lifetime of the equipment. If the equipment does not last for the entire 5 year reasonable useful lifetime, the supplier must replace the equipment at no charge to Medicare or the beneficiary (42 CFR 414.210(e) (4)). When billing for the Medicare initial date of service, standard documentation requirements, including proof of delivery, apply (PIM 4.26, 5.8).

Results from recent reviews have uncovered several misconceptions about the documentation requirements for claims for a beneficiary who previously received equipment from a prior insurer. Some of these mistakes include:

1. Changes to the proof of delivery (POD) are not annotated. This is incorrect. Any changes or corrections on the POD must show that the beneficiary or caregiver has signed or initialed, and dated the changed document.
2. The proof of delivery provided is from the delivery with the previous payer which is not appropriate to demonstrate proof of delivery for a new Medicare item. For items that require a CMN, the "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DME Information Form (DIF) or the start date on the written order.

Suppliers must follow the standard documentation language regarding the elements required for proof of delivery based on the method of delivery. For more information refer to the Supplier Manual.

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

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

MLN Matters® Number: MM8161
Related Change Request (CR) #: CR 8161
Related CR Release Date: December 28, 2012
Related CR Transmittal #: R2624CP
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

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

What You Need to Know
Medicare will use the April 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 April 1, 2013, with dates of service from April 1, 2013, through June 30, 2013.

Change Request (CR) 8161, from which this article is taken, instructs Medicare Contractors to implement the April 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 implement the revised January 2013, October 2012, July 2012, and April 2012 files. Make sure that your billing staffs are aware of these changes.

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, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website.)

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

Files	Effective for Dates of Service
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 20
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
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012

Additional Information
You can find the official instruction, CR 8161, issued to your FI, carrier, A/B MAC, DME MAC, and RHHI by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2624CP.pdf on the CMS website.

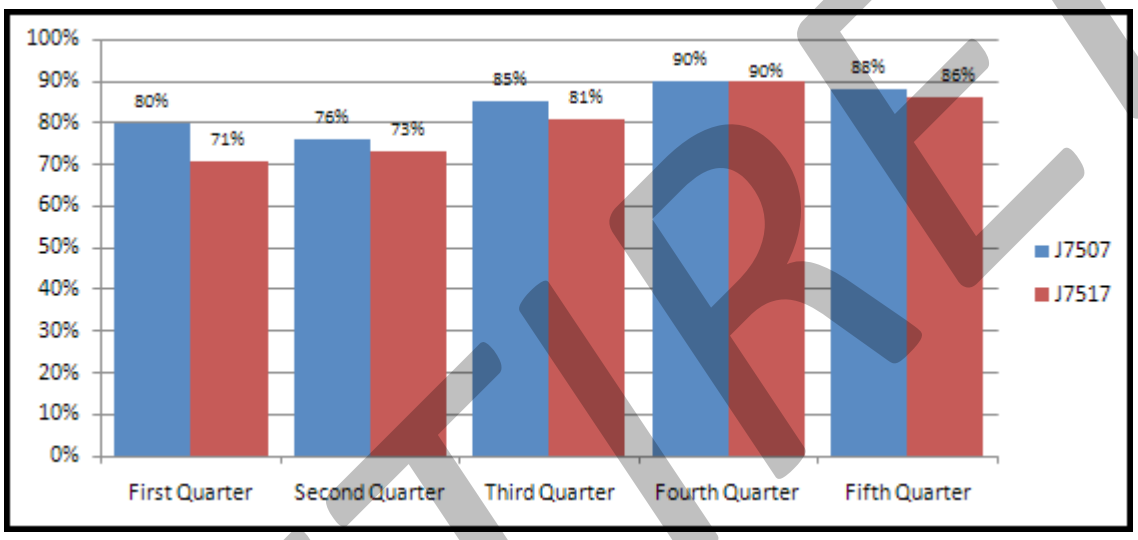
Fifth Quarter Results of Widespread Prepayment Review of Claims for Immunosuppressive Drugs (HCPCS J7507, J7517, J7518 and J7520)

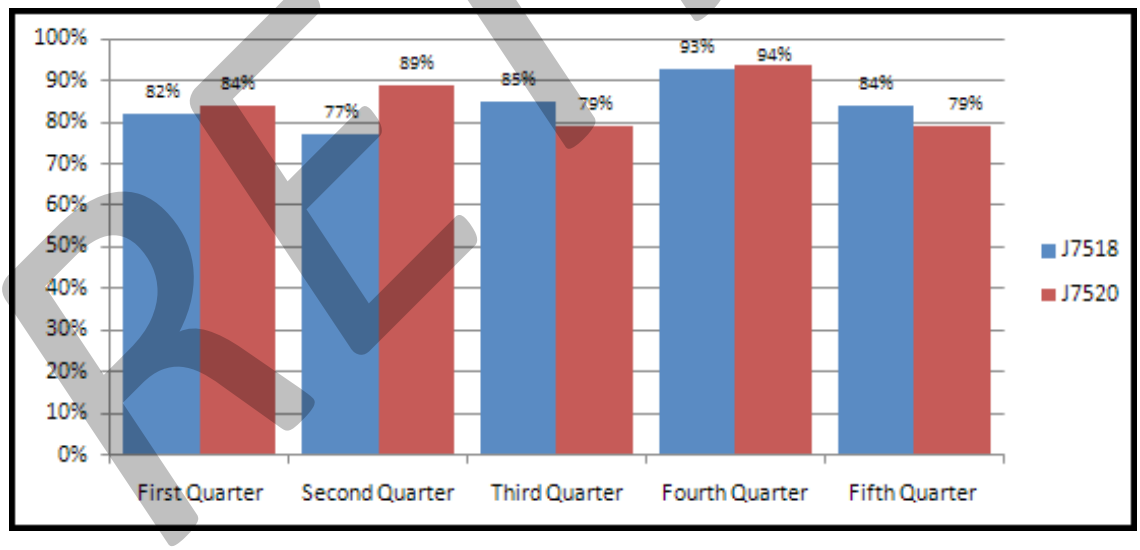
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes J7507, J7517, J7518 and J7520. The fifth quarter edit effectiveness results from 09/09/2012 through 12/08/2012 are as follows:

- The J7507 review involved 2,900 claims of which 2,521 were denied. This resulted in an overall error rate of 88%.
- The J7517 review involved 1,937 claims of which 1,632 were denied. This resulted in an overall error rate of 86%.
- The J7518 review involved 800 claims of which 668 were denied. This resulted in an overall error rate of 84%.
- The J7520 review involved 268 claims of which 213 were denied. This resulted in an overall error rate of 79%.

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





Primary Documentation Errors that Resulted in Denial of Claims

- 31% of J7507 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.
- 32% of J7517 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.
- 35% of J7518 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines.
- 32% 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.

- 24% of J7507 claims received a denial as there was no beneficiary exhaustion or invalid beneficiary exhaustion.
- 24% of J7517 claims received a denial as there was no beneficiary exhaustion or invalid beneficiary exhaustion.
- 23% of J7518 claims received a denial as there was no beneficiary exhaustion or invalid beneficiary exhaustion.
- 21% of J7520 claims received a denial as there was no beneficiary exhaustion or invalid beneficiary exhaustion.

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.

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 from 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.
- 12% of J7507 claims received a denial as the Proof of Delivery was invalid.
- 12% of J7517 claims received a denial as the Proof of Delivery was invalid.
- 10% of J7518 claims received a denial as the Proof of Delivery was invalid.
- 12% of J7520 claims received a denial as the Proof of Delivery was invalid.

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.

DOCUMENTATION CONT'D

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 the Proof of Delivery is after the Date of Service.
- 7% of J7517 claims received a denial as the Proof of Delivery is after the Date of Service.
- 7% of J7518 claims received a denial as the Proof of Delivery is after the Date of Service.
- 7% of J7520 claims received a denial as the Proof of Delivery is after the Date of Service.

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.

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

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

EDUCATIONAL

DME on Demand – PMD Prior Authorization Demo

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

This session will include:

- Acronyms and Definitions
- PAR Submission
- Scenarios
- Medicare and Other Insurance
- Coverage Criteria
- 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 – Repairs and Replacements

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

This session will include:

- Acronyms and Definitions
- Repairs
- Replacement
- Modifiers
- 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.

This program has the prior approval of the American Academy of Professional Coders for 1 continuing education hour.

Granting of prior approval in no way constitutes endorsement by the academy of the program content or the program sponsor.

Further Details on the Revalidation of Provider Enrollment Information

MLN Matters® Number: SE1126 Revised

Note: This article was revised on December 3, 2012, to provide the calendar year 2013 fee amount of $532.00. All other information remains the same.

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

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

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

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

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and
- Mail your supporting documents and certification statement to your MAC.

Background
Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. **Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted.**

CMS has reevaluated the revalidation requirement in the Affordable Care Act, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015. **IMPORTANT:** This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through internet-based PECOS or by completing the appropriate 855 application form.

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

The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

- **For providers NOT in PECOS** – the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.

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

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

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

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

Section 6401(a) of the Affordable Care Act also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $505 for Calendar Year (CY) 2011. For CY 2012, the fee is $523.00 and for CY 2013, the fee is $532.00. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

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

Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. **Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.**

Additional Information

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

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

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

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

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

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

Implementation of Provider Enrollment Provisions in CMS-6028-FC

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

Note: This article was was revised on December 3, 2012, to provide the application fee amount of $532.00 for calendar year 2013. All other information remains the same.

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

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

This rule finalized provisions related to the:

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

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

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

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

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

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

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

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

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

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is $505.00. The fee for January 1, 2012 through December 31, 2012 is $523.00 and for January 1, 2013, through December 31, 2013, the fee is $532.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

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

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

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

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

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

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

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

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

(a) Considerable bad debt expenses,

(b) Significant amount of charity care/financial assistance furnished to patients, (c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

(d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

(e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

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

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

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

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

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

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

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

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

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

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

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

ENTERAL NUTRITION

First Quarter Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4035 and B9002)

Current Review Results
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes B4035 and B9002. The first quarter edit effectiveness results from July 2012 through October 2012 are as follows:

The B4035 review involved 615 claims of which 571 were denied. This resulted in an overall error rate of 92%.

The B9002 review involved 48 claims of which 40 were denied. This resulted in an overall error rate of 85%.

Primary Documentation Errors that Resulted in Denial of Claims

- 31% of B4035 claims received a denial as no/invalid beneficiary exhaustion was provided.
- 6% of B9002 claims received a denial as no/invalid beneficiary exhaustion was provided.

For DEPOS 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.

- 8% of B4035 claims received a denial as the proof of delivery submitted was dated prior to the date of service on the claim.
- 9% of B9002 claims received a denial as the proof of delivery submitted was dated prior to the date of service on the claim.
- 8% of B4035 claims received a denial as no documentation was received.
- 7% of B9002 claims received a denial as no documentation was received.

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.

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 B4035 claims received a denial as the physician order has incomplete or missing elements.
- 5% of B9002 claims received a denial as the physician order 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

ENTERAL NUTRITION CONT'D

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 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 Enteral Nutrition Local Coverage Determination (LCD) L11568 and Policy Article A25361.

Suppliers can also review specific policy resources for enteral nutrition on the NAS 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 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#tools.

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

HCPCS B4150 – Notification of Widespread Prepayment Probe Review

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

HCPCS	Description
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube.

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

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

- Treating physician's dispensing and written order; and,
- Documentation of verbal order (if item is dispensed based on a verbal order); and,
- DME Information Form (DIF); and ,
- Patient's medical records (physician medical records, hospital records, patient diagnosis, nursing home records, home care nursing note, physical/occupational therapy notes, dietician notes) that may support medical necessity of the codes billed; and,
- Medical records to support tube replacement, pump feedings, calories under 750 calories and over 2,000 and/or the need for special formula; and,
- Proof of delivery; and,
- The Advanced Beneficiary Notice (if applicable); and,
- Any other supporting documentation.

Failure to supply the above requested information within 45 days of the date on the letter will result in the claim being denied. Please fax requested documentation and a copy of the ADR letter to 1-701-277-7888 or mail to Noridian 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 Enteral Nutrition Local Coverage Determination (LCD) L11568 and Policy Article A25361.

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

Results of Widespread Prepayment Probe Review of Enteral Nutrition (HCPCS B4154)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS code B4154. This probe edit effectiveness results from July 2012 through December 2012 are as follows:

The B4154 review involved 100 claims of which 98 were denied. This resulted in an overall error rate of 98%.

Primary Documentation Errors that Resulted in Denial of Claims

- 24% 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.

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 one (1) month quantity at a time.

- 14% of B4154 claims received a denial as incomplete/missing elements on physician's 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

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.

- 13% of B4154 claims received a denial as no documentation was received.

ENTERAL NUTRITION CONT'D

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

- 11% of B4154 claims received a denial as no written order for the kits/pump/pole supplies.

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

Enteral nutrition may be administered by syringe, gravity, or pump. Some enteral patients may experience complications associated with syringe or gravity method of administration.

If a pump (B9000-B9002) is ordered, there must be documentation in the patient's medical record to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not reasonable and necessary.

The feeding supply kit (B4034-B4036) must correspond to the method of administration indicated in question 5 of the DME Information Form (DIF). If it does not correspond, it will be denied as not reasonable and necessary.

If a pump supply kit (B4035) is provided and if the medical necessity of the pump is not documented, it will be denied as not reasonable and necessary.

The codes for feeding supply kits (B4034-B4036) are specific to the route of administration. Claims for more than one type of kit code delivered on the same date or provided on an ongoing basis will be denied as not reasonable and necessary.

More than three nasogastric tubes (B4081-B4083), or one gastrostomy/jejunostomy tube (B4087-B4088) every three months is not reasonable and necessary.

Going Forward
Based on high error rate, Noridian Administration Services will close this probe review and begin a widespread targeted review on HCPCS codes B4154.

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 NAS 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 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#tools.

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

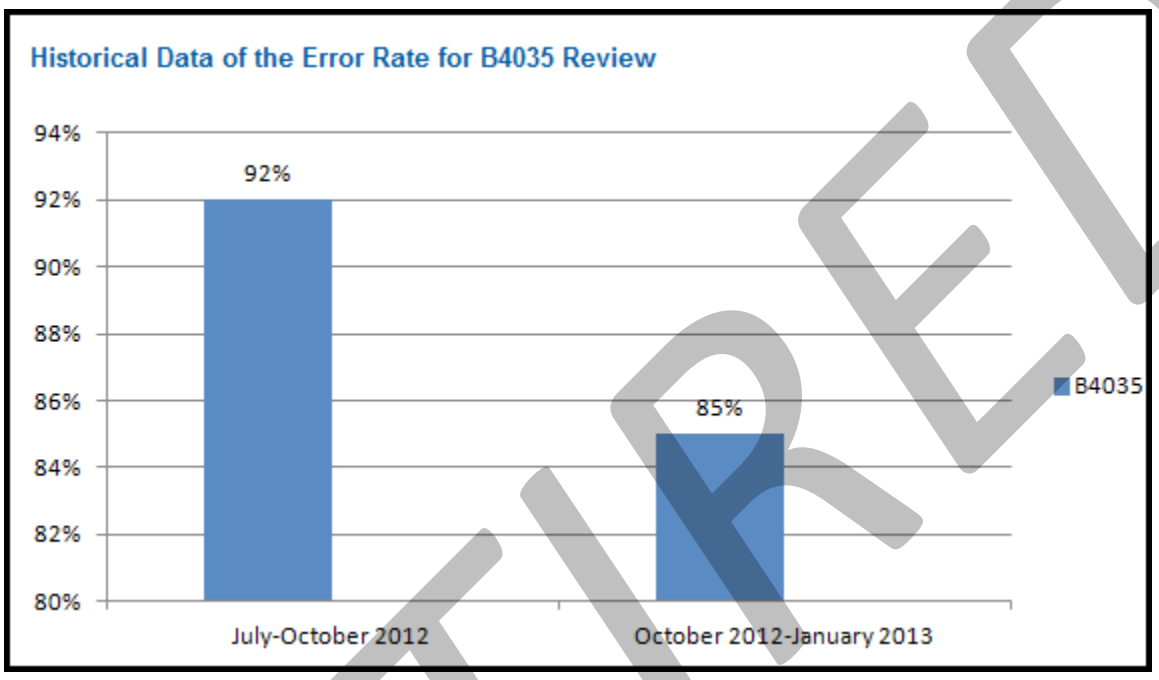
Second Quarter Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4035)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code B4035. The results are as follows:

- The B4035 review involved 1,161 claims of which 950 were denied. This resulted in an overall error rate of 85%.

Historical Data of the Error Rate for B4035 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 24% 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.

- 19% of 4035 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.

- 9% of B3035 claims received a denial as the proof of delivery submitted was dated prior to the date of service on the claim.

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.

ENTERAL NUTRITION CONT'D

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 B4035 claims received a denial as the physician order 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 Administration Services will continue with the Prepayment Widespread Review on B4035.

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 NAS 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 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/.

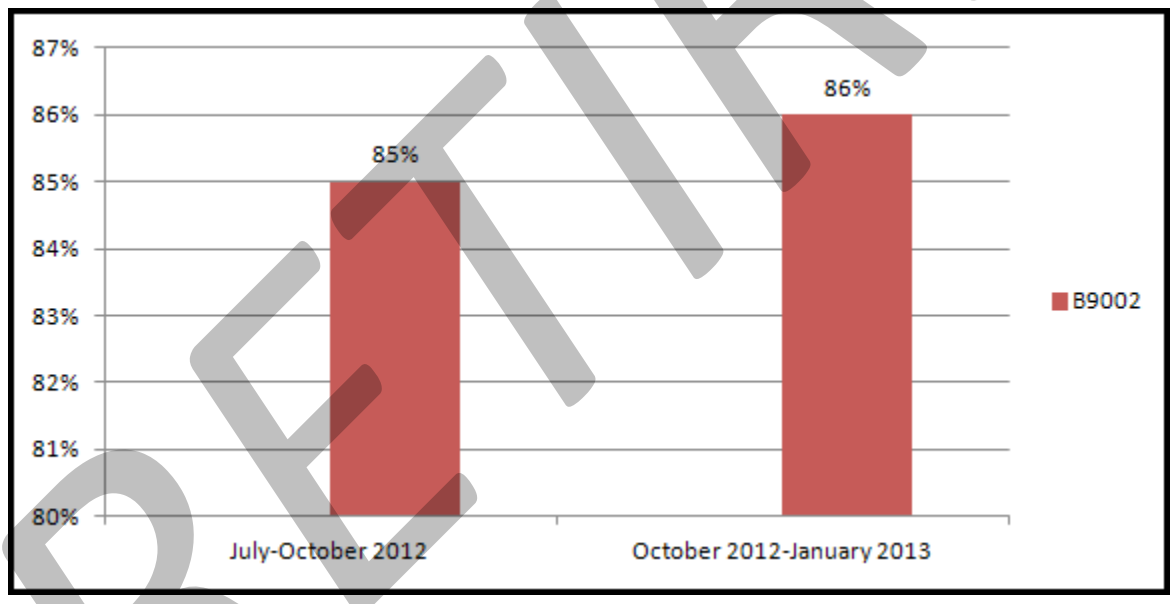
Information about probe/error validation reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

Second Quarter Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B9002)

Current Review Results
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code B9002 are as follows:

- The B9002 review involved 130 claims of which 108 were denied. This resulted in an overall error rate of 86%.

Historical Data of the Error Rate for B9002 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 16% of B9002 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 9002 claims received a denial as physician signature date on order is after the date of service with no verbal/ dispensing order submitted.

ENTERAL NUTRITION CONT'D

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.

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.

- 8% of B9002 claims received a denial as the physician order has incomplete or missing elements.

ENTERAL NUTRITION CONT'D

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.

- 7% of B9002 claims received a denial as 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."

ENTERAL NUTRITION CONT'D

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.

ENTERAL NUTRITION CONT'D

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

Going Forward
Based on the results of the review, DME MAC D will close the widespread review for B9002 (Enteral nutrition infusion pump – with alarm).

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 NAS 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 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

ESRD

Quarterly Update to ESRD Prospective Payment System

MLN Matters® Number: MM7858 Revised
Related Change Request (CR) #: CR 7858
Related CR Release Date: June 8, 2012
Related CR Transmittal #: R2486CP
Effective Date:
Effective date for updates to the ESRD PPS consolidated billing requirements: October 1, 2012
Effective date for updates to ESRD-related drugs and biologicals: July 1, 2012
Implementation Date: October 1, 2012

Note: This article was revised on November 30, 2012, to provide the correct CPT code on page 3 for "Assay of Magnesium." All other information remains the same.

Provider Types Affected
This MLN Matters® Article for Change Request (CR) 7858 is intended for physicians, other providers, and suppliers including End Stage Renal Disease (ESRD) facilities and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers who submit claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), carriers, and/or A/B Medicare Administrative Contractors (A/B MACs)) for ESRD supplies and services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7858 which provides the October 2012 Quarterly Update to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS). See the Background and Additional Information Sections of this article for further details regarding this ESRD PPS update.

Background
The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf) required the implementation of an End Stage Renal Disease (ESRD) Prospective Payment System (PPS) effective January 1, 2011.

The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an

outpatient dialysis treatment. This includes supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services. Consolidated billing edits established with the implementation of the ESRD PPS prevent payment to other providers and suppliers billing for renal dialysis services. The ESRD PPS provides payment adjustments for co-morbid conditions identified by specific ICD diagnosis codes. The ICD diagnosis codes are updated annually and effective each year on the first day of October. The ESRD PPS also includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS also provides outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care. You can find a list of 1) specific diagnosis codes that are eligible for a co-morbidity payment adjustment, 2) items and services that are subject to the ESRD PPS consolidated billing requirements, and 3) outlier services at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html on the CMS website.

ICD Diagnosis Coding Updates
There are no new or revised ICD diagnosis codes to implement for the October 1, 2012, ESRD PPS Quarterly Update.

Consolidated Billing Changes
ESRD-Related Drugs and Biologicals

The following new code is being added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management treatment effective July 1, 2012.

Added HCPCS Code	Short Description	Long Description
Q2047	Peginesatide injection	INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS)

Peginesatide is used as anemia management for ESRD patients on dialysis, therefore the drug is considered to be always ESRD-related. Separate payment for Q2047 (Peginesatide) will not be made with or without the AY modifier.

The claims shall process the line item as covered with no separate payment under the ESRD PPS and under the ESRD PPS portion of the blended payment during the transition effective October 1, 2012. However, ESRD facilities that are receiving a blended payment during the transition will receive separate payment under the composite rate portion of the blend effective July 1, 2012.

In accordance with 42 CFR 413.237(a)(1), HCPCS code Q2047 (Peginesatide) is considered to be an eligible outlier service, and it will be included in the outlier calculation when CMS provides a fee amount on the Average Sales Price (ASP) pricing file.

ESRD-Related Equipment and Supplies
The following HCPCS code is being added to the list of items and services that are subject to ESRD PPS consolidated billing requirements effective October 1, 2012:

Added HCPCS Code	Long Description
A6216	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

HCPCS code A6216 is ESRD-related, however, this supply can be used for reasons other than for the treatment of ESRD, and it is covered under other Medicare benefit categories. Therefore, A6216 may be billed by DME suppliers with the AY modifier to receive separate payment effective October 1, 2012.

Changes to Items and Services that Qualify as an Outlier Service
CMS is removing the following Current Procedural Terminology (CPT) code 83735 (Assay of Magnesium) from the list of outlier services. The "Assay of Magnesium" laboratory test was a composite rate service under the basic case-mix adjusted composite rate system. Consequently, it is considered a renal dialysis service under the ESRD PPS. Therefore, this laboratory test does not qualify as an outlier service under 42 CFR 413.237 effective October 1, 2012.

CR7858 also includes the following two attachments:

ESRD CONT'D

- Attachment A which contains the following four tables:
  - DME ESRD Supply HCPCS for ESRD PPS Consolidated Billing Edits;
  - DME ESRD Supply HCPCS Not Payable to DME Suppliers
  - Labs Subject to ESRD Consolidated Billing,
  - Drugs Subject to ESRD Consolidated Billing; and
- Attachment B (Outlier Services) which includes one table with three sections:
  - Oral and Other Equivalent Forms of Injectable Drugs,
  - Laboratory Tests, and
  - Syringes.

Note: The tables in Attachments A & B are updated to include codes A6216 and Q2047, as presented in this article, where applicable.

Additional Information
The official instruction, CR7858, issued to your DME MACs, FIs, and A/B MACs, regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2486CP.pdf on the CMS website.

GLUCOSE MONITORS

Glucose Monitors and Supplies LCD – Clerical Correction

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) published a revised local coverage determination (LCD) for Glucose Monitors and Supplies. Language was inadvertently omitted from the Indications and Limitations of Coverage and/or Medical Necessity section. Specifically, the previous policy in criteria d and e stated:

d. The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.

e. The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

The statement in criterion d regarding documentation in the patient's medical record describing the specific reason(s) for the additional supplies was inadvertently omitted from the revised and consolidated coverage criteria in the LCD effective 11/1/2012. The LCD is being republished with the language reinstated in criteria b. Criterion b now reads:

b. The treating physician has seen the patient, 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 patient's medical record the specific reason for the additional materials for that particular patient; and,

The DME MACs are issuing this corrected LCD with the effective date unchanged. We apologize for the omission.

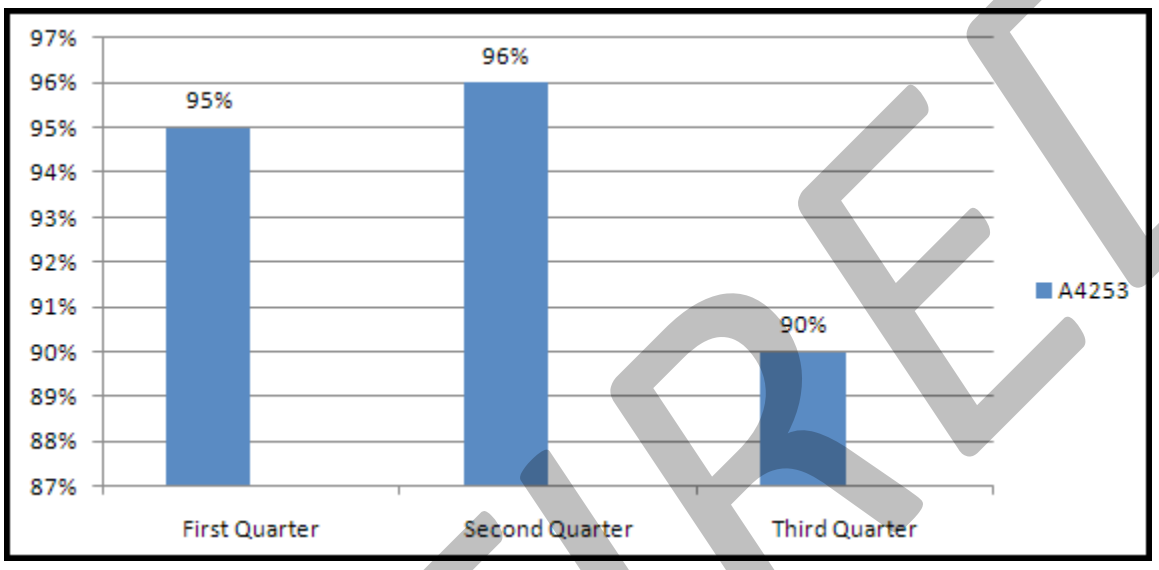
Third Quarter Results of Widespread Prepayment Review of Claims for Glucose Monitors (HCPCS A4253KS)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes A4253KS. The third quarter edit effectiveness results from October 2012 through December 2012 are as follows:

The A4253KS review involved 4,832 claims of which 4,720 were denied. This resulted in an overall error rate of 90%.

Historical Data of the Error Rate for A4253KS Review



Primary Documentation Errors that Resulted in Denial of Claims

- 23% of A4253KS claims received a denial as Criteria D not met.

For services performed prior to 11/01/12-The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.

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

- 17% of A4253KS claims received a denial as Criteria F not met.

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

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

- 9% of A4253KS claims received a denial as Criteria E not met.

For services performed prior to 11/01/12-The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

- 7% of A4253KS claims received a denial as use of an Incorrect Modifier.

If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a patient who is not treated with insulin injections.

If the patient is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted.

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 Glucose Monitors Local Coverage Determination (LCD) L196 and Policy Article A33673.

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

Noridian 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.

Widespread Prepayment Target Review for Diabetic Supplies

Edit Effectiveness for Second Quarter
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A4253KS (Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips) and the second quarter edit effectiveness results from July 2012 through September 2012 are as follows:

This review identified 4596 claims of which 4493 were denied. A total of 2044 claims were denied for no response to the additional documentation requested. This resulted in an overall error rate of 96%. Due to this high error rate, NAS will continue with the widespread target review.

The following are the top reasons for denial:

- Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines
- Invalid or no beneficiary evidence of exhaustion
- Documentation submitted did not support testing frequency above utilization guidelines
- Claims were submitted with incorrect modifier

GLUCOSE MONITORS CONT'D

An in-depth explanation of the denial reasons are as follows:

A. 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.

B. 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 per PIM 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:

   a. Beneficiary's name or authorized representative if different than the beneficiary

   b. A description of each item that is being requested

   c. Date of refill request

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

C. There must be documentation from the treating physician in the medical record the specific reason for the additional materials when ordering a frequency of testing that exceeds the utilization guidelines. The treating physician must see the patient and evaluate their diabetes control within 6 months prior to ordering quantities that exceed the utilization guidelines. Also, there must be documentation that adequately supports that the patient is actually testing at a frequency that corroborates with the quantity of supplies that have been dispensed. New documentation must be present at least every six months when supplies exceed utilization guidelines.

D. If the patient is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted. The KX modifier must not be used for a patient who is not treated with insulin injections, and then the KS modifier is to be used.

To be eligible for coverage of home blood glucose monitor and related accessories and supplies, the patient must meet the criteria as noted in LCD L196 and Policy Article A33673, which can be found on our website: https://www.noridianmedicare.com/dme/coverage/lcd.html.

It is important for suppliers to be familiar with the documentation requirements outlined in the Glucose Monitor LCD and Policy Article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

The following references were used in the medical review of these claims and can be accessed on our NAS DME website at https://www.noridianmedicare.com/dme/:

- Glucose Monitors LCD (L196)
- Glucose Monitors Policy Article (A33673)
- Home Blood Glucose Monitors (National Coverage Determination 40.20)
- Supplier Manual
- Program Integrity Manual: http://www.cms.gov/manuals/downloads/pim83c04.pdf
- In addition, there are other educational resources that can be found on our website: https://www.noridianmedicare.com/dme/coverage/resources/glucose_monitors.html

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

MLN Matters® Number: MM8043
Related Change Request (CR) #: CR 8043
Related CR Release Date: September 7, 2012
Related CR Transmittal #: R2527CP
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

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

Provider Action Needed
This article announces that Change Request (CR) 8043 is a recurring update notification that provides the annual Home Health (HH) consolidated billing update, effective January 1, 2013. Make sure your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (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). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to 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 a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points
Effective January 1, 2013, the following HCPCS code is added to the HH consolidated billing supply code list:

- A4435 - Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each.

In addition, there are 3 codes on the supply code list for which long descriptions are being modified to remove the words "pad size". They are as follows:

- A6021 - Collagen dressing, sterile, size 16 sq. in. or less, each
- A6022 - Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each
- A6023 - Collagen dressing, sterile, size more than 48 sq. in., each

Additional Information
The official instruction, CR 8043, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2527CP.pdf on the CMS website.

More information on HH consolidated billing is in the "Medicare Claims Processing Manual," Chapter 10, Section 20, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf on the CMS website.

HOSPITAL BEDS

Widespread Prepayment Review for E0260 Hospital Beds - Edit Effectiveness for Second Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0260 and the second quarter edit effectiveness results from July 27, 2012 through October 26, 2012 are as follows:

The results of the review, for the item E0260, identified 3104 claims of which 2842 were denied. A total of 759 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 92%. Total dollars allowed were $419,270.35; total dollars denied were $455,321.43.

Due to this high error rate, NAS will continue with the widespread complex review for E0260.

The following are the top reasons for denial:

1. Criteria for fixed height bed not met.
2. Criteria for semi electric bed not met.
3. No documentation received.
4. Proof of delivery prior to date of service on claim.

An in-depth explanation of the denial reasons are as follows:

A. 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.

B. 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.

C. 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)
   - Quantity delivered
   - Date delivered
   - Beneficiary (or designee) signature and date of signature

HOSPITAL BEDS CONT'D

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.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination for Hospital Beds and Accessories L11572 and Policy Article A37079 and Supplier Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html

LCD AND POLICY ARTICLE REVISIONS

LCD and Policy Article Revisions Summary for December 6, 2012

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

Ankle-Foot/Knee-Ankle-Foot Orthoses
Policy Article
Revision Effective Date: 01/01/2013
CODING GUIDELINES:
Revised: Height definition for AFO codes L1900, L1910-L1990

Spinal Orthoses: TLSO and LSO
LCD
Revision Effective Date: 01/01/2013
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a "detailed written order"
HCPCS CODES AND MODIFIERS:
Added: L0621 & L4002
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: Prescription (Order) requirements, detailed written order requirements, proof of delivery requirements, general medical record requirements and repair/replacement requirements
APPENDICES:
Added: PIM citation

Spinal Orthoses: TLSO and LSO
Policy Article
Revision Effective Date: 01/01/2013
CODING GUIDELINES:
Added: Definition of rigid and semi-rigid orthotic
Added: Clarification on spinal orthotic functionality
Added: L0621

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

LCD AND POLICY ARTICLE REVISIONS CONT'D

LCD Revisions Summary for December 28, 2012

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

Glucose Monitors
LCD
Revision Effective Date: 11/01/2012 (December Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Clerical Correction: Re-inserted documentation requirement for high utilization beneficiaries inadvertently omitted from 11/01/2012 publication
DOCUMENTATION REQUIREMENTS:
Added: Consumable and non-consumable supplies to Refill documentation
Deleted: Method 3 under Proof of Delivery (Delivery to nursing facility) since this does not apply to DME
Clerical Correction: Re-inserted documentation requirement for high utilization beneficiaries inadvertently omitted from 11/01/2012 publication
Clerical Correction: Consolidated redundant written order requirements in Policy Specific Documentation Requirements

Note: The information contained in this article is only a summary of revisions to the LCD. For complete information on any topic, you must review the LCD.

MOBILITY DEVICES

First Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices K0813 and K0821

Jurisdiction D DME MAC Medical Review completed the widespread prepayment review of claims for power mobility devices with HCPC codes K0813 (Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds) and K0821(Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds).

- The K0813 review involved 0 claims of which 0 were denied. This resulted in an overall error rate of 0%.
- The K0821 review involved 1 claim of which 1 was denied. This resulted in an overall error rate of 100%.

DME MAC D will close these reviews for K0813 and K0821. By closing this file, medical review will no longer request documentation for the specified criteria. Contractors are required to monitor the utilization patterns of suppliers and observe for medical necessity and appropriate coding practices. Claims will be subject to the routine claims processing system and edits that may suspend claims for review.

It is important for suppliers to be familiar with the documentation requirements as outlined in the Power Mobility Device LCD and policy article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

- Power Mobility Devices LCD L23598
- Power Mobility Devices PA A41127
- Medicare Program Integrity Manual Chapter 4
- DME MAC Jurisdiction D Supplier Manual

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of the HCPCS code K0822. The first quarter edit effectiveness results from July 2012 through October 2012 are as follows:

- The K0822 review involved 90 claims of which 75 were denied. This resulted in an overall error rate of 85%.

Primary Documentation Errors that Resulted in Denial of Claims

- 25% of K0822 claims received a denial as Criterion C not met.

It is expected that the patient's medical records will reflect the need for the care provided.

C. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.
- 11% of K0822 claims received a denial as Criterion B not met.

It is expected that the patient's medical records will reflect the need for the care provided.

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

- 10% of K0822 claims received a denial as no or invalid detailed product description submitted.
- **Once the supplier has determined the specific power mobility device that is appropriate for the patient 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 PWC or POV. **A date stamp or equivalent must be used to document the supplier receipt date.** The detailed product description must be available on request.
- 9% of K0822 claims received a denial as the face-to-face submitted was incomplete or missing elements.

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

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

- Symptoms that limit ambulation
- Diagnoses that are responsible for these symptoms
- Medications or other treatment for these symptoms
- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the patient can walk without stopping
- Pace of ambulation

MOBILITY DEVICES CONT'D

- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
- What has changed to now require use of a power mobility device
- Ability to stand up from a seated position without assistance
- Description of the home setting and the ability to perform activities of daily living in the home

Physical examination that is relevant to mobility needs:

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

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

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

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

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's mobility needs.

Going Forward
Based on the 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 Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127.

Suppliers can also review specific policy resources for Power Mobility Devices on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and 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#tools.

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

First Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0824)

Current Review Results
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of the HCPCS code K0824. The first quarter edit effectiveness results from July 2012 through October 2012 are as follows:

- The K0824 review involved 18 claims of which 12 were denied. This resulted in an overall error rate of 77%.

Primary Documentation Errors that Resulted in Denial of Claims

- 28% of K0824 claims received a denial as Criterion C not met.

It is expected that the patient's medical records will reflect the need for the care provided.

C. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.
- 20% of K0824 claims received a denial as no documentation 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.

- 12% of K0824 claims received a denial as Criterion B not met.

It is expected that the patient's medical records will reflect the need for the care provided.

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

- 12% of K0824 claims received a denial as no or invalid detailed product description submitted.

Once the supplier has determined the specific power mobility device that is appropriate for the patient 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 PWC or POV. A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request.

Going Forward
Based on the 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 Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127.

Suppliers can also review specific policy resources for Power Mobility Devices on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and 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#tools.

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

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

Current Review Results
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of the HCPCS code K0825. The first quarter edit effectiveness results from July 2012 through October 2012 are as follows:

The K0825 review involved 126 claims of which 110 were denied. This resulted in an overall error rate of 89%.

Primary Documentation Errors that Resulted in Denial of Claims

- 28% of K0825 claims received a denial as Criterion C not met.

It is expected that the patient's medical records will reflect the need for the care provided.

C. The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.
- 14% of K0825 claims received a denial as Criterion B not met.

It is expected that the patient's medical records will reflect the need for the care provided.

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

- 9% of K0825 claims received a denial as Criterion M not met.

M. The patient's home provides adequate access between rooms, maneuvering space and surfaces for the operation of the power wheelchair that is provided.

- 9% of K0825 claims received a denial as Criterion N not met.

It is expected that the patient's medical records will reflect the need for the care provided.

Use of a power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it in the home. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver.

- 8% of K0825 claims received a denial as no or invalid detailed product description submitted.

Once the supplier has determined the specific power mobility device that is appropriate for the patient 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 PWC or POV. **A date stamp or equivalent must be used to document the supplier receipt date**. The detailed product description must be available on request.

Going Forward
Based on the 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 Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127.

Suppliers can also review specific policy resources for Power Mobility Devices on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and 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#tools.

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

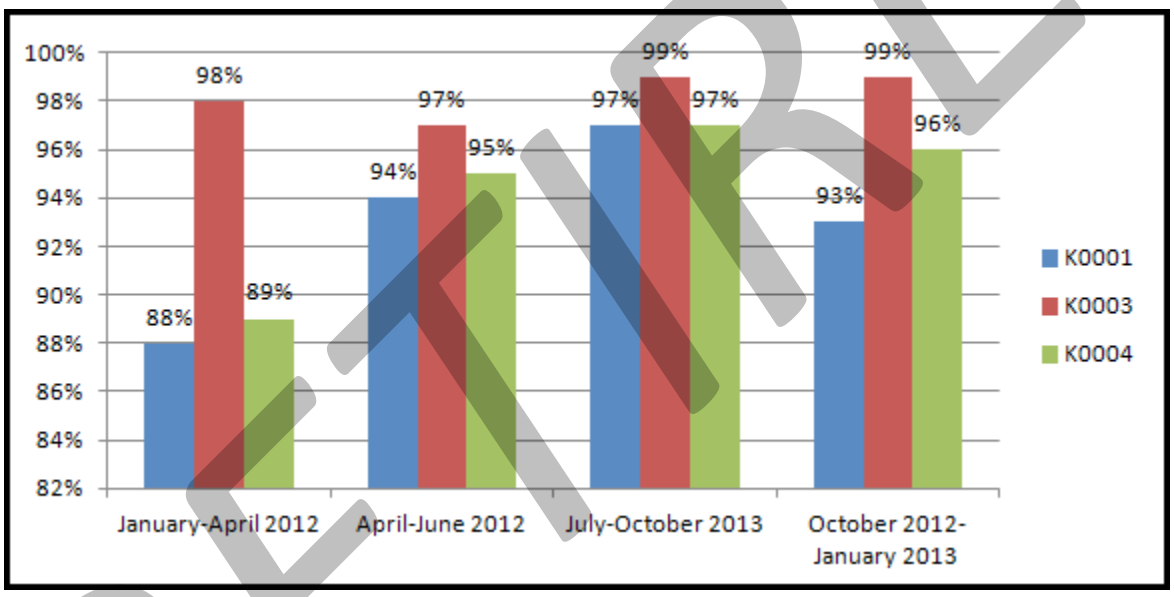
Fourth Quarter Results of Widespread Prepayment Review of Claims for Manual Wheelchairs (HCPCS K0001, K0003 and K0004)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003 and K0004. The fourth quarter edit effectiveness results from October 2012 through January 2013 are as follows:

- The K0001 review involved 717 claims of which 668 were denied. This resulted in an overall error rate of 93%.
- The K0003 review involved 370 claims of which 365 were denied. This resulted in an overall error rate of 99%.
- The K0004 review involved 355 claims of which 335 were denied. This resulted in an overall error rate of 96%.

Historical Data of the Error Rate for K0001, K0003 and K0004 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 21% of K0001 claims received a denial as criteria B not met.
- 17% of K0003 claims received a denial as criteria B not met.
- 16% of K0004 claims received a denial as criteria B not met.

The beneficiary's medical records do not support criteria B.

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

- 21.8% of K0003 claims received a denial as criteria 1 and 2 not met for K0003.
- 22% of K0004 claims received a denial as criteria 1 and/or 2 not met for K0004.

The beneficiary's medical records do not support criteria 1 and 2 for K0003

A lightweight wheelchair (K0003) is covered when a beneficiary:

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

The beneficiary's medical records do not support criteria 1 and/or 2 for K0004.

A high strength lightweight wheelchair (K0004) is covered when a beneficiary meets the criteria (1) and/or (2):

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

- 19% of K0001 claims received a denial as criteria A not met.
- 16% of K0003 claims received a denial as criteria A not met.
- 16% of K0004 claims received a denial as criteria A not met.

The beneficiary's medical records do not support criteria A.

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

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

   - 10% of K0003 claims received a denial as criteria C not met.
   - 10% of K0004 claims received a denial as criteria C not met.
   - 14% of K0001 claims received a denial as criteria C not met.

The submitted documentation does not support criteria C

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

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

- 9% of K0001 claims received a denial as criteria F not met.

The beneficiary's medical records do not support criteria F

F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

Going Forward
Based on high error rate, Noridian Administration Services will continue with the Prepayment Widespread Review for K0001, K0003 and K0004.

Education Resources

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

Noridian 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#tools.

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

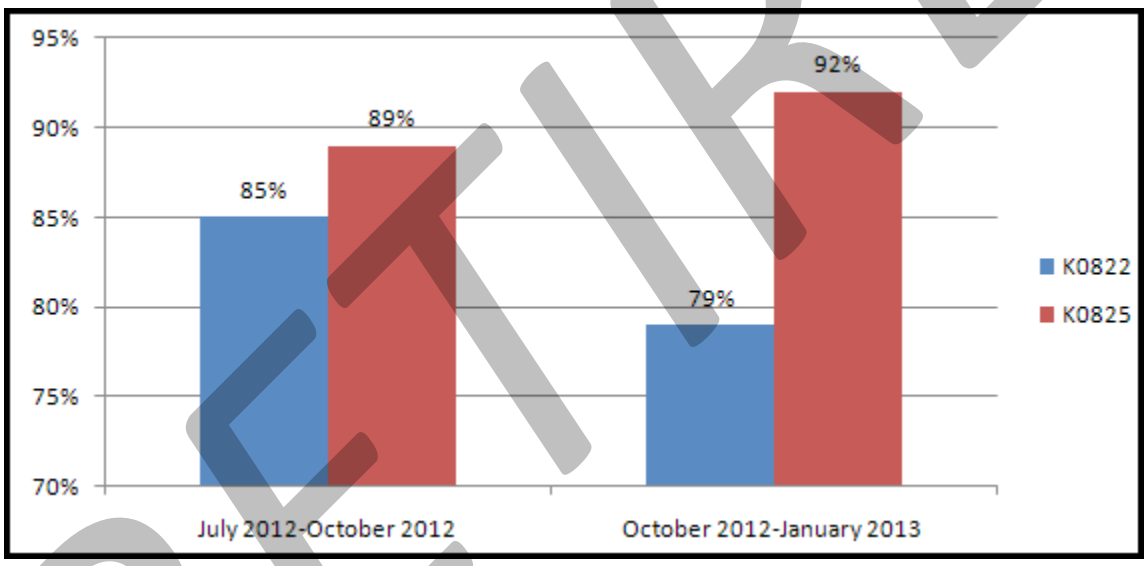
Second Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0822 and K0825)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0822 and K0825. The second quarter edit effectiveness results from October 2012 through January 2013 are as follows:

- The K0822 review involved 105 claims of which 83 were denied. This resulted in an overall error rate of 79%.
- The K0825 review involved 143 claims of which 130 were denied. This resulted in an overall error rate of 92%.

Historical Data of the Error Rate for K0822 and K0825 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 20% of K0822 claims received a denial as criterion C not met.
- 27% of K0825 claims received a denial as criterion C not met.

It is expected that the patient's medical records will reflect the need for the care provided.

The patient does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options and other appropriate nonpowered accessories.

- 8% of K0822 claims received a denial as criterion B not met.
- 15% of K0825 claims received a denial as criterion B not met.

MOBILITY DEVICES CONT'D

It is expected that the patient's medical records will reflect the need for the care provided.

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

Additional Reminder Regarding Power Mobility Device Documentation
This is a reminder to ensure that suppliers are submitting a valid Detailed Product Description (DPD) per the following requirements:

- **Once the supplier has determined the specific power mobility device that is appropriate for the patient 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 PWC or POV. A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request.

Going Forward
Based on the 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 Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127.

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

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

NATURAL DISASTERS

Hurricane Sandy's Impact upon Medicare Claims Crossover Process

The Centers for Medicare & Medicaid Services' (CMS) Coordination of Benefits Contractor (COBC), which administers both Medicare coordination of benefits and crossover claims functions on behalf of CMS, was directly impacted by Hurricane Sandy. CMS wanted to alert all providers, physicians, suppliers, and their billing vendors about the impact that Hurricane Sandy has had upon the Medicare claims crossover process. As a result of Hurricane Sandy's impacts, the Medicare claims crossover process is operating more slowly than normal. Therefore, providers, physicians, and suppliers may be experiencing a delay in payments from their patients' supplemental payers.

Billing vendors representing providers, physicians, and suppliers need take no action to bill their patients' supplemental payers, as we expect all outstanding crossover claims to be transmitted to supplemental payers by the end of November 2012.

Thank you for your patience and understanding as the Northeast collectively recovers from the aftermath of an unprecedented weather event.

10/30/2012 External Breast Prosthesis Webinar

Event Summary

On October 30, 2012, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) conducted a Webinar on External Breast Prostheses. During this Webinar, information was provided to assist suppliers in understanding the medical policy for External Breast Prostheses and Medicare's requirements for documentation.

Suppliers are strongly encouraged to review available resources on each of the DME MACs Web sites, including the medical policies:

- Jurisdiction A – NHIC, Corp.: http://www.medicarenhic.com/dme
- Jurisdiction B – National Government Services: http://www.NGSMedicare.com
- Jurisdiction C – CGS Administrators LLC.: http://www.CGSMedicare.com
- Jurisdiction D – Noridian Administrative Services: https://www.noridianmedicare.com/dme/

Question and Answer Summary

The following questions were asked via the chat feature for this Webinar. These questions are ones that were unable to be addressed during the Webinar. Please note that questions and answers may have been rewritten for clarity.

Enrollment/Assignment of Claims

1. **Are ordering physicians required to be enrolled into the internet-based Provider Enrollment Chain & Ownership System (PECOS)?**
   Answer: The Centers for Medicare & Medicaid Services (CMS) is expanding claim edits for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). As a result, in the near future, implementation of specific edits will occur that will restrict DMEPOS suppliers from receiving payment from Medicare for items that you order if you do not have a current enrollment in the Medicare PECOS. Furthermore, for any DMEPOS item to qualify for coverage by Medicare it must be ordered by a physician or a practitioner who is eligible to order such item. Physicians or practitioners must be enrolled in PECOS and must be registered in the system and have a specialty that is eligible to order DMEPOS items for Medicare beneficiaries.

2. **Is a supplier required to accept assignment on a specific amount of bras or may they all be submitted as nonassigned?**
   Answer: A non-participating supplier may choose to accept assignment or submit the claim as non-assigned. A supplier may not attempt to circumvent the Medicare allowed amount

limitation by "fragmenting" his/her bills. Bills are "fragmented" when a supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion.

A Participating supplier must accept assignment for all items and services furnished to Medicare beneficiaries.

3. **Is nonassigned acceptable for each claim or for each day?**
   Answer: Suppliers who are nonparticipating with the Medicare program are able to choose assignment or nonassigment for claims submitted to Medicare on a claim by claim basis.

4. **May a nonparticipating supplier accept assignment on a prosthetic and nonassignment on bras if they are delivered on the same day?**
   Answer: No. A supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion.

5. **If a physician orders a total for the year of six bras and the beneficiary wishes to purchase from a participating supplier a 7th bra, can the supplier collect payment for the 7th bra from the member as self pay?**
   Answer: Per the CMS Internet-only Manual (IOM) Publication 100-04 *Medicare Claims Processing Manual,* chapter 1, §70.8.8.6, per Section 1848(g)(4) of the Social Security Act, suppliers are required to submit claims to the DME MAC for services furnished. Suppliers who fail to submit a claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

   Suppliers who have knowledge of an individual that is on Medicare should submit all items/services to the DME MAC for consideration of payment.

   Note: Suppliers will not violate mandatory claims submission rules under Section1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary's request by their choice of Option 2 on the revised Advance Beneficiary Notice of Noncoverage (ABN).

6. **What certification does a fitter require to provide these items?**
   Answer: Medicare does not require a certification however; suppliers should verify if their state requires a license to fit and provide these services.

7. **Does fitting require a licensed person?**
   Answer: Currently, Medicare does not require a licensed person to perform fittings.

8. **If a supplier does not accept assignment on a claim, then the beneficiary pays in full, how does the supplier notify the secondary insurance in order to not receive the payment?**
   Answer: Suppliers will need to verify with the requirements from the secondary payer. Once Medicare processes the claim, information will appear on the Medicare remittance advice.

9. **If a supplier is nonparticipating and doesn't accept assignment, is accreditation still required?**
   Answer: Yes. All DMEPOS suppliers who serve Medicare beneficiaries and meet the supplier standards listed in this chapter must enroll and obtain a Provider Transaction Access Number (PTAN) with the National Supplier Clearinghouse (NSC).

   Before enrolling with the NSC, you must obtain a National Provider Identifier (NPI). Applying for an NPI is a separate process from enrollment with the NSC. This information will be found under the supplier enrollment chapter of your supplier's manual. This chapter outlines the enrollment requirements that you must meet in order to receive payment in the Medicare program as a DMEPOS supplier.

10. **For nonparticipating suppliers who submit all claims as nonassigned, does the beneficiary pay the supplier upfront for all charges?**
    Answer: Yes, then Medicare provides payment to the beneficiary.

11. **If a supplier chooses to switch to nonparticipating, does the supplier have the right to bill Medicare on a claim-by-claim basis of accepting assignment?**
    Answer: Yes, nonparticipating suppliers have the option of accepting assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs).

12. **Are there any "negative" consequences of being a nonparticipating supplier?**
    Answer: Nonparticipating suppliers are not included in the Medicare Participating Suppliers Directory (MEDPARD) prepared by the NSC. This directory serves as an aid to the beneficiary in selecting a supplier who accepts assignment as the beneficiary will have less out-of-pocket costs.

13. If non par and customer wants a bra for $75, do they pay the full amount up front and then Medicare billed and payment sent to them. Or do we collect difference at the time of delivery?
Answer: Nonparticipating suppliers billing as nonassigned can collect payment in full from the beneficiary who will then receive reimbursement directly from Medicare for the allowed amount.

14. How do suppliers switch to nonparticipating status?
Answer: Open enrollment forms (CMS-460, Participation Agreement Form) are mailed to all active suppliers every November. If an existing non-participating supplier wants to become participating, then the agreement form must be received during open enrollment and postmarked before December 31 of that year.

If a participating supplier wants to become nonparticipating, they can request to become non-participating by sending the request to the NSC on their company letterhead. The request must be postmarked before December 31 of that year to become non-participating effective January 1 of the next year

15. What is the purpose of revalidation when accreditation is required every three years?
Answer: CMS requires that all DMEPOS suppliers with Medicare billing privileges re-enroll with the Medicare program every three years through the NSC.

16. When suppliers revalidates their application, are they are able to switch their status to nonparticipating?
Answer: Suppliers can change their participation status annually. To switch from participating to nonparticipating, a supplier just needs to submit a request to the NSC on their company letterhead, postmarked before December 31 for the change to take effect January 1 of the following year.

17. If a company chooses not to be a Medicare supplier, is a Medicare beneficiary able to go to that company and submit their own claim for reimbursement?
Answer: Beneficiaries are strongly encouraged to receive DMEPOS items from Medicare suppliers. If a beneficiary opts to receive DMEPOS items from a non-Medicare supplier, they are able to submit their own claim for reimbursement however; they are only able to receive reimbursement from Medicare one time per DMEPOS item. If a beneficiary opts to receive DMEPOS items from a non-Medicare supplier, they are able to submit claims to Medicare for reimbursement by completing the Patient's Request for Medical Payment CMS-1490S Form.

18. Do mastectomy suppliers have to be enrolled in PECOS as well as the ordering physicians?

Answer: In order to submit claims to any of the four DME MACs, a supplier of mastectomy products must be enrolled with the NSC. CMS is currently providing warning messages with claims that are processed when the ordering physician is not in PECOS. Suppliers should work with these physicians in order to avoid claim denials when CMS announces the start date for warning messages to switch to denials.

Coverage

19. If a beneficiary requires a new prosthesis due to weight gain or loss, will Medicare allow reimbursement?

Answer: An external breast prosthesis of a different type can be covered at any time if there is a change in the patient's physiological condition necessitating a different type of item. If the patient's medical condition changes, this should be documented in the patient's medical record. The patient's ordering physician would also be required to submit a new order which explains the need for a different type of breast prosthesis. The order must be kept in the supplier's files but need not be submitted with the claim.

20. What is Medicare's reasoning for not covering custom breast prosthetics?

Answer: The medical necessity for the additional features of a custom fabricated prosthesis (L8035) compared to a prefabricated silicone breast prosthesis has not been established, and therefore, if an L8035 breast prosthesis is billed, it will be denied as not reasonable and necessary.

21. If a beneficiary receives a foam form may they receive reimbursement from Medicare for a silicone prosthetic in six months?

Answer: The useful lifetime expectancy for silicone breast prostheses is 2 years. The useful lifetime expectancy for nipple prostheses is 3 months. For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is 6 months. Replacement sooner than the useful lifetime because of ordinary wear and tear will be denied as noncovered.

22. May a beneficiary be fitted for a L8015 prior to surgery and delivered after the surgery?

Answer: Yes. An external breast prosthesis garment, with mastectomy form (L8015) is covered for use in the postoperative period prior to permanent breast prosthesis or as an alternative to mastectomy bra and breast prosthesis.

23. How many bras may a beneficiary receive per year?
Answer: The policy does not identify a specific quantity. These items are paid based on medical necessity evidenced in the patient's medical record.

24. Can a Medicare beneficiary receive mastectomy bra if she does not have a need for full breast prosthesis?
Answer: Yes, a Medicare beneficiary may receive bras if a partial prosthesis is needed.

25. Is a beneficiary required to receive a L8015 prior to a L8030 or may a beneficiary receive the items at any time?
Answer: No, a beneficiary is not required to receive a L8015 prior to a L8030. However, L8015 may be covered as an alternative to mastectomy bra **and** breast prosthesis.

26. May beneficiaries switch between an L8020 and L8030 if the Reasonable Useful Lifetime (RUL) has expired for each?
Answer: Yes a beneficiary may switch between both prostheses as long as the RUL has expired.

27. With the Women's Cancer Act, is there a way to get the mastectomy sleeves covered by Medicare?
Answer: The policy article (PA) states the Mastectomy Sleeve L8010 does not meet the definition of a prosthesis therefore is denied as non-covered.

28. When providing prosthesis is the medical record from the surgery required or will a follow-up visit note be sufficient?
Answer: A breast prosthesis is considered for coverage for a patient who has a mastectomy, ICD-9-CM diagnosis V10.2, V45.71, 174.0-174.9, 198.81, 233.0, 457.0. During a review it would be expected the medical record would contain sufficient detailed information to justify coverage.

29. Are suppliers able to deliver a L8020 and L8030 at same time?
Answer: No. The L8020 is the fabric, foam, or fiber filled prosthesis and has a RUL of 6 months; the L8030 the silicone or equal mastectomy form with a RUL of 2 years. The local coverage determination (LCD) tells the supplier the Medicare Program will pay for only one breast prosthesis per side for the useful lifetime of the prosthesis. Two prostheses, one per side, are allowed for those persons who have had bilateral mastectomies. More than one external breast prosthesis per side will be denied as not reasonable and necessary.

30. Does Medicare consider reimbursement for breast prosthesis due to a congenital malformed breast?
Answer: Coverage is included for the conditions listed in the medical policy. If a potentially covered condition is missing, an LCD reconsideration should be submitted explaining the need and justification for the proposed addition. Suppliers may use the DME MACs Web sites for further information on submitting an LCD reconsideration.

31. Why must a beneficiary wait until the surgery is completed in order to receive their post-op camisole?
Answer: The medical necessity for the items listed in the medical policy cannot be established until after mastectomy. The beneficiary may be fitted for their post-op mastectomy bra or external breast prosthesis garment, with form, prior to surgery but the delivery of the item(s) may not take place until the surgery has been completed.

32. May a beneficiary receive more than one L8015 in a lifetime?
Answer: Yes, the medical policy for External Breast Prostheses does not specify the quantities of bras or external breast prosthesis garment, with form, which are covered. This is determined by the medical necessity and what is reasonable and necessary for the individual patient. Medical records from the physician should reflect and support what is dispensed to the beneficiary.

33. Will Medicare consider payment for a breast prosthesis for the other side non-mastectomy side to even the beneficiary out?
Answer: No, Medicare will only pay for the affected side.

34. If a beneficiary receives a L8020 after surgery then 4-6 weeks later is able to tolerate a L8030, will the supplier receive reimbursement for the L8030 due to progression in medical need?
Answer: All prosthetic devices are determined to be or not be reasonable and necessary by means of the medical records provided from the physician. The RUL of the L8020 is 6 months.

35. For the L8015, if the camisole is sold prior to surgery but the date of service on the claim is after the surgery, is the acceptable?
Answer: The L8015 (external breast prosthesis garment, with form, post) is not payable if dispensed prior to surgery (medical necessity for the L8015 cannot be established until after completed surgery). The date of service on the claim must match the date the beneficiary received the item so a supplier cannot dispense the item on one date and bill for it on a later date.

36. Are beneficiaries able to receive a breast prosthesis and a nipple prosthesis on the same date?
Answer: If a beneficiary receives a breast prosthesis for one side and the nipple prosthesis for the other, yes this can be considered for reimbursement. If the beneficiary is receiving a breast and nipple prosthesis for the same side, this would not be considered for coverage on both prostheses.

37. What process should a supplier follow if the beneficiary wants a camisole after her healing period?
Answer: The L8015 (external breast prosthesis garment, with form, post) is covered prior to a permanent breast prosthesis being dispensed or as an alternative to a breast prosthesis and mastectomy bra. Once the breast prosthesis and bras are dispensed, Medicare will no longer cover the camisole. Prior to this, a supplier can continue to dispense camisoles under the original order.

Medical Documentation/Signature Requirements

38. What information should be present in the medical records to justify the quantity and frequency of mastectomy bras?
Answer: The LCD does not specify a usual quantity of bras. The number provided should be sufficient to accommodate daily wearing and a usual laundering interval. As a durable supply, they may be replaced when they are no longer able to provide sufficient support.

39. Are the medical records required to specific what type of breast prostheses the beneficiary should receive?
Answer: No. The LCD does not require the medical records to specify the type of prosthesis.

40. What resources are available for suppliers to provide to ordering physicians in regards to stamp signatures are not acceptable for Medicare purposes?
Answer: Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in *Program Integrity Manual*, Pub. 100-08, Chapter 3, §3.3.2.4.

41. On a Certificate of Medical Necessity (CMN) the physician's name and credentials are listed in Section A. If the signature on the CMN is not legible does the physician need to print their name under their signature?
Answer: Medicare does not have an official required CMN for external breast prosthesis. Supplier-created CMNs are classified as supplier created documentation and therefore are insufficient to justify reimbursement. Medicare discourages the use of such documents and

encourages suppliers to work closely and collaboratively with the prescribing physician to ensure that sufficient information is included in the actual medical record to justify payment.

42. If a supplier has a signature log however; the physician's signature is different, what recourse does a supplier have?
Answer: The supplier may want to obtain an attestation statement from the physician. Additional information regarding CMS' signature requirements, including signature logs and attestation statements, can be found in MLN Matters article MM6698.

43. What constitutes a designee for signature purposes?
Answer: A designee is someone other than the beneficiary who signs for the 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 relationship of the designee to the beneficiary should be noted on the document. The signature of the designee should be legible. Below are the acceptable designees for each piece of documentation:

- ABN
  - Notifiers are responsible for determining who may act as a beneficiary's authorized representative for the purposes of ABN issuance under applicable State or other law. An individual who may make health care and financial decisions on a beneficiary's behalf (e.g. the beneficiary's legal guardian or someone appointed according to a properly executed "durable medical power of attorney") is an authorized representative. **If the beneficiary has a known, legally appointed representative, the ABN must be issued to the existing representative.** If a beneficiary does not have an existing representative and one is necessary, an authorized representative may be appointed for purposes of receiving notice following CMS guidelines and as permitted by State and Local law.
  - An individual authorized under state law to make health care decisions
  - An individual exercising explicit legal authority on the beneficiary's behalf, may be the authorized representative of the beneficiary with respect to receiving notice
  - The spouse, unless legally separated
  - An adult child
  - A parent
  - An adult sibling
  - A close friend (defined as "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available")

- Assignment of Benefits
  - Legal guardian
  - Representative payee
    - a person designated by the Social Security Administration or other governmental agency to receive an incapable beneficiary's monthly cash benefits
  - Authorized representative
    - acts on behalf and in best interest of the beneficiary and is usually a parent, legal guardian of minor, or legal guardian of an adult who has been declared incompetent
  - Relative
  - Friend
  - Representative of an institution providing care or support
  - Governmental agency providing assistance
- Proof of Delivery
  - Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary

Suppliers should review the supplier manuals available on the DME MACs Web sites.

44. What does the clinical course in the medical records section entail?
Answer: The term "clinical course" is not used in this medical policy. In general the term "clinical course" refers to the history or progression of a medical condition. This information was provided in the presentation as additional information that may appear in the medical records for the beneficiary.

45. What is deemed as a medical necessity for product eligibility after reconstruction surgery?
Answer: If after a beneficiary has received reconstructive surgery and a breast prosthesis is required, Medicare will consider payment for the prosthesis and bras. If after reconstructive surgery a prosthesis is not required, bras would not be covered since there is not a prosthesis.

46. Since mastectomy is a permanent condition, may medical documentation stating the diagnosis be from years back?
Answer: Yes, the medical records may advise a diagnosis that is beyond the seven year time frame Medicare advises for medical records. Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the medical policy.

47. For medical record information, may this be documented by the supplier or is it required to be documented by the ordering physician?
Answer: Medical information collected by the supplier is deemed insufficient, by itself, even if signed by a physician, to justify payment. Information from the medical record is the primary source used to justify reimbursement.

48. How should functional levels be documented in the medical records?
Answer: Functional levels are not a requirement for the external breast prostheses medical policy. This information was provided in the presentation as additional information that may appear in the medical records for the beneficiary.

49. Who is responsible for maintaining a signature log?
Answer: A publication titled "Signature Requirements" is now available in downloadable format from the Medicare Learning Network® on the CMS Web site. This fact sheet is designed to provide education on Signature Requirements to healthcare providers, and includes information on the documentation needed to support a claim submitted to Medicare for medical services. Ultimately, all documentation requirements affect the suppliers claim; on behalf of a health care provider, you may create a signature log at any time, and Medicare Contractors will accept all submitted signature logs regardless of the date when they were created.

50. Are suppliers required to send their notes to the ordering physician?
Answer: No, suppliers are not required to send their notes to ordering physicians.

51. For mail order suppliers, what information should be noted in the medical records in order to determine skin condition, balance and posture?
Answer: These are not elements of any reasonable and useful criteria contained in the LCD. This information was provided in the presentation as additional information that may appear in the medical records for the beneficiary. Medicare expects suppliers of prosthetic items to maintain sufficient detailed information in their records to demonstrate that the item provided was properly fit and able to be used by the beneficiary.

52. For a lost or stolen prosthesis, what documentation is required to support the replacement prosthesis?
Answer: Suppliers will need to follow the documentation requirements specified in the medical policy for a new item along with documentation of current usage/need. For documentation of lost or stolen, suppliers may include the following documentation:

- Reason for replacement
- Medical records
- Police reports

- Written explanations from the beneficiary

53. Can the typed printed name of the ordering physician be above the illegible signature?
Answer: A publication titled "Signature Requirements" is now available in downloadable format from the Medicare Learning Network® on the CMS Web site. This fact sheet is designed to provide education on Signature Requirements to healthcare providers.

54. In order to support medical necessity, what information should be in the medical records?
Answer: There must be sufficient information to demonstrate that the applicable coverage criteria are met.

55. If a form from the ordering physician has an illegible signature, may the ordering physician circle their name if there is a listing of physicians or are they required to print their name below their signature?
Answer: The preferred would be the printed name below the signature, although the name within the letterhead circled is also acceptable. A publication titled "Signature Requirements" is now available in downloadable format from the Medicare Learning Network® on the CMS Web site. This fact sheet is designed to provide education on Signature Requirements to healthcare providers

56. If a medical entry or documentation contains written and typed information, is this acceptable for valid documentation?
Answer: A partially typed and partially handwritten record is a valid part of the medical record if it is properly authenticated.

57. Does there need to be a face to face visit associated with the prescription?
Answer: Medicare payment policy does not require a specific face-to-face visit but it is required that the beneficiary's medical records support medical necessity.

58. Will a photo of the patient's status (post-mastectomy) serve in the event physician medical records are not obtainable?
Answer: A photograph in the supplier's records is not an acceptable or adequate substitute for documentation in the beneficiary's medical record to support medical necessity. A photograph may be part of the comprehensive medical record.

Coding

59. Would a form L8020 or L8030 and bras L8000 be covered for a beneficiary who has diagnosis of 174.9 and had a lumpectomy vs a mastectomy?

Answer: This is possible for reimbursement. A breast prosthesis is covered for a patient who has had a mastectomy, ICD-9-CM diagnosis codes V10.3, V45.71, 174.0-174.9, 198.81, 233.0 or 457.0. A mastectomy bra (L8000) is covered for a patient who has a covered mastectomy form (L8020) or silicone (or equal) breast prosthesis (L8030) when the pocket of the bra is used to hold the form/prosthesis.

60. What garments are classified under Healthcare Common Procedure Coding System (HCPCS) L8002?
Answer: Codes L8001 and L8002 describe a bra with integrated breast prosthesis, either unilateral or bilateral, respectively. Products described by codes L8001 and L8002 may be constructed of any material (e.g., cotton, polyester or other materials), with any type or location of closure, any size, with or without integrated structural support (e.g., underwire).

61. Can a V code be the primary diagnosis when billing?
Answer: Yes. A breast prosthesis is covered for a patient who has had a mastectomy, ICD-9-CM diagnosis codes V10.3, V45.71, 174.0-174.9, 198.81, 233.0 or 457.0.

62. Have the accepted diagnosis codes been expanded?
Answer: The diagnoses for a breast prosthesis to be covered are: ICD-9-CM codes V10.3, V45.71, 174.0-174.9, 198.81, 233.0 or 457.0.

63. Does "shelf" camisole pertain to a specific style of camisole or does it mean an "over the counter" item that can be purchased at a department store?
Answer: Code L8015 describes an external breast prosthesis garment, with mastectomy form, used post mastectomy. For additional information regarding coding refer to the Pricing, Data Analysis and Coding (PDAC) Contractor's Web site.

64. What is diagnosis code 457.0?
Answer: The diagnosis code of 457.0 is Postmastectomy Lymphedema Syndrome.

65. For Medicare to reimburse on a claim, is a diagnosis code required?
Answer: Yes. The ICD-9 diagnosis code must be included on each claim for the prosthesis or related item.

66. What modifier should be reported when billing for replacement items?
Answer: The RA modifier is used for replacement items that have met the RUL or due to irreparable damage, theft, or loss.

If a new item was provided due to a change in physiological condition, a different HCPCS code would be billed and this would not be considered a "replacement" of the original item. The RA modifier would not be used in this situation.

All other applicable modifiers per the medical policy are also required to be submitted on the claim.

67. In the event that a pocketed bra (L8000) is not available in the needed size (e.g.: G, H, I cups) are suppliers able to modify the bra with a pocket and bill it as a pocketed bra?
Answer: To be covered under the Medicare DME MAC the item must be pocketed; the PA states products described by code L8000 may be constructed of any material, with any type or location of closure, any size, with or without integrated structural support. Although there are manufacturers that provide the larger sizes one is to assume this can be provided in this manner at no extra cost to the beneficiary.

68. Is the shelf camisole billed as L8015?
Answer: No. Medicare's description of the L8015 is an external breast prosthesis garment, with form used post mastectomy; so the shelf style camisole without breast form should not be coded with HCPCS code L8015.

69. If a beneficiary has a dual mastectomy how does a supplier bill the prostheses to receive reimbursement?
Answer: The assumption here is "dual" meaning bilateral, the right (RT) and left (LT) modifiers must be used with these codes. When the same code for bilateral items (left and right) is billed on the same date of service; bill for both items on the same claim line using the RTLT modifiers and 2 units of service. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding. Bras and similar inherently bilateral items (L8000 - L8002, L8015) are exempt from the RTLT requirement**.**

70. Are suppliers required to report the V diagnosis code on the claim first?
Answer: No, suppliers of these products are not required to report the V diagnosis code as the first diagnosis code; however, suppliers should report the primary diagnosis code first.

71. Are suppliers able to bill a camisole with integrated shelf bra as a L8000?
Answer: No. Medicare's description of the L8000 is breast prosthesis, mastectomy bra.

72. Are compression garments for lymphedema billed as HCPCS L8015?
Answer: Code L8015 describes an external breast prosthesis garment, with form used post mastectomy. Mastectomy sleeves used for the treatment of lymphedema can be billed using code L8010 (but are noncovered by Medicare).

Dispensing and Detailed Written Orders

73. If a dispensing order specifies a number of bras that the supplier does not see is medically necessary, may the supplier reduce the dispensing due to not medically necessary. For example, the dispensing order specifies 12 bras however; it is determine the beneficiary should only receive 3?
Answer: A supplier can obtain an ABN in this situation and bill only for the items that are believed to be reasonable and necessary. However, there is not a set number of bras a beneficiary can receive. It is based upon the treating physician's order and the medical record. A supplier is able to dispense a number lower than what is written on the dispensing order.

74. What is the definition of dispensing?
Answer: Dispensing is when a supplier receives an order from a treating physician and provides items/services to a Medicare beneficiary.

75. If a beneficiary presents a valid detailed written order to the supplier, is the supplier required to contact the ordering physician for a dispensing order?
Answer: No. If the supplier has the detailed written order (DWO), a dispensing order would not be necessary. The supplier may dispense the item based on the DWO and submit a claim to Medicare.

76. If the beneficiary wants a different bra style number then previously dispensed, is a new order required?
Answer: No, all mastectomy bras without integrated prosthesis are coded as L8000, Changing from one manufacturer or style to another does not change the coding or the medical necessity therefore a new order is not needed. Changing from an L8000 to an L8001 or L8002 would require a new order.

77. Are the quantity and the frequency required to be on a DWO?
Answer: Frequency is not applicable for this medical policy. The quantity is required on the DWO along with the following:

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

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

- Item(s) to be dispensed
- Quantity to be dispensed
- Number of refills

78. When is a new DWO required?
Answer: A new DWO is required when:

- A new order is required when there is a change in the item(s), frequency of use, or amount prescribed.
- A new order is required on a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy.
- A new order is required when an item is replaced.
- A new order is also required when there is a change in supplier.
- A new order is required if there is a change in length of need or a previously established length of need expires.
- Also when required by any state or federal laws

79. For how long is a prescription for bras valid?
Answer: For Medicare purposes, a prescription (DWO) is valid for as long as the prescription indicates, consistent with applicable laws. Suppliers should verify with their state regulations if a new prescription is required at certain intervals.

80. Is it sufficient for the detailed written order to specify the quantity of bras or is it required to be on the start order (dispensing order) and obtained before delivery of mastectomy bras?
Answer: Quantity is not required on the dispensing order but is required on the DWO.

81. Are supplies able to have a valid lifetime DWO?
Answer: A DWO must follow all federal and state guidelines. CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.2.4 will provide further guidelines. Medicare requires a new DWO:

- A new order is required when there is a change in the item(s), frequency of use, or amount prescribed
- A new order is required on a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy.
- A new order is required when an item is replaced.
- A new order is also required when there is a change in supplier.
- A new order is required if there is a change in length of need or a previously

established length of need expires.
- Also when required by any state or federal laws

A new order is required when an item is being replaced because the item is worn or the patient's condition has changed. Your records should also include beneficiary-specific information regarding the need for the replacement item. This information should be maintained in your files and be available to the DME MACs or other review contractors upon request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in claim(s) denial.

A new physician's order is required before replacing lost, stolen, or irreparably damaged items to reaffirm the medical necessity of the item. Proof of loss or damage through documentation such as a police report, picture, or corroborating statement should be submitted with the claim.

82. If a beneficiary contacts a supplier may the supplier contact the physician in order to receive a dispensing or DWO?
Answer: Yes, once the beneficiary makes contact with the supplier you may then document that contact, and the detailed written order will be provided to the physician for concurrence and signature.

83. When requesting a dispensing or DWO from a physician because the beneficiary has contacted the supplier, is it acceptable for the supplier to advise what the beneficiary is eligible for?
Answer: A supplier can assist the physician in determining what item will work best for a particular beneficiary (and will often complete the detailed description on the detailed written order) but the physician must initiate the dispensing order after evaluating the beneficiary.

84. Does the dispensing order alone have to have quantity or can the detail written order clarify the quantity in amount of time?
Answer: The detailed written order should clearly indicate a quantity and duration for the mastectomy bras. This is not a requirement for dispensing orders.

85. If a prescription states 6 bras but no refill information, is the order valid for one year or does it need to specify one year on the order?
Answer: Because the order is unclear, it should be sent back to the physician for clarification, preferably requesting a new, replacement order to minimize confusion; both frequency/duration and quantity should be specified on the detailed written order.

86. Are diagnosis codes required on a DWO?
Answer: A diagnosis code is not required on the detailed written order but must be supported by documentation in the beneficiary's medical record.

87. May nurses sign a dispensing order?
Answer: Nurse practitioners, clinical nurse specialists and physician assistants can order DMEPOS items if they meet the conditions listed in CMS publication 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.5-5.6.

88. 120: Is it a Medicare requirement for the number of bras to be dispensed to appear on the DWO?
Answer: Yes, for items dispensed on a periodic basis (including mastectomy bras), a quantity must be included on the detailed written order.

Advance Beneficiary Notice of Noncoverage/Upgrades

89. When completing an ABN, what dollar amount is reported in section F?
Answer: Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D) of the ABN. In general, it is expected that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially may still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.

90. Are suppliers able to submit breast prostheses bras as upgrade billing? If so, what are the appropriate steps to take to ensure correct billing?
Answer: Upgrades involve situations in which the upgraded item or component is more than what is medically necessary. For items with a different HCPCS code than the item that will be covered by Medicare, this distinction between products is easy to determine. Differing products contained within the same HCPCS code generally are considered as equivalent to one another. A difference in pricing for items classified within the same HCPCS code is not sufficient to justify an upgrade. For bras coded within the same HCPCS code, upgrade billing is not permitted. Please refer to CMS IOM Pub 100-04, *Medicare Claims Processing Manual,* Chapter 20, §120 for information on billing procedures for ABN upgrades.

91. How should a supplier execute an ABN when medical records cannot be obtained or the medical records are insufficient?
Answer: An ABN should be issued prior to dispensing a DMEPOS item expected to be disallowed for the following reasons:

- Services are not medically reasonable and necessary

- Prohibition on unsolicited telephone contacts
- Supplier number requirements not met
- Advance Determination of Medicare Coverage (ADMC) denial
- Noncontracted suppliers in a competitive bidding area (CBA)

92. If the beneficiary refuses to sign an ABN when the situation warrants one, do suppliers have the option to deny services or tell the beneficiary they are unable to bill Medicare?
Answer: If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign and may list witnesses to the refusal on the notice although this is not required. If a beneficiary refuses to sign a properly delivered ABN, the notifier should consider not furnishing the item/service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option. If the supplier chooses to dispense the item, the claim should be submitted with the GZ modifier if the ABN was not properly executed.

93. Who can witness a refusal to sign an ABN and does it apply to all DMEPOS products?
Answer: If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign and may list witnesses to the refusal on the notice although this is not required. If a beneficiary refuses to sign a properly delivered ABN, the notifier should consider not furnishing the item/service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option.

94. If a supplier is submitting a nonassigned claim, is an ABN required in order to hold the beneficiary liable for the full amount of the supplier charges of service?
Answer: No, an ABN is not required to hold the beneficiary liable for the full charge if Medicare makes payment on the claim. If the claim is expected to be denied, yes the supplier will need to execute an ABN to hold the beneficiary liable for the charges.

95. If a supplier mails an ABN via certified mail, follows up with phone calls, and the records indicate this information, are suppliers able to bill the beneficiary if the ABN is witnessed by supplier staff?
Answer: When a beneficiary refuses to sign an ABN, two members of the supplier would be required to sign the ABN. One will sign the ABN annotating the beneficiary refused to sign and the other will sign and annotate they witnessed the first signature.

96. Are suppliers able to bill items as upgrades due to the item the beneficiary received costs more than what Medicare allows?

Answer: No. Cost is not sufficient to justify an upgrade.

97. Are suppliers able to collect the difference in what Medicare allows and what the supplier charges for a L8000 if an ABN has been properly executed?
Answer: Mastectomy bras are not eligible to be billed as upgrades so an ABN is not applicable. The Medicare allowed amount is all a participating supplier can receive as payment in full when billing for the L8000. Nonparticipating suppliers have the option to bill mastectomy bras as nonassigned claims in order to receive full payment directly from the beneficiary—in these cases, an ABN is not required.

Request for Refills

98. If the ordering physician does not indicate refills on the dispensing order or in the medical record, but just ordered four bras, are suppliers to interpret this as to dispense four bras, no refills or one bra every three months?
Answer: Yes either is acceptable.

99. Are suppliers required to inspect the beneficiary's bras prior to dispensing additional bras as refills?
Answer: For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement, 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 properly. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

100. Are suppliers permitted to contact beneficiaries with a signed consent and request to be notified when eligible for the next three month supply of bras?
Answer: Yes the suppliers may contact their existing customers in order to provide continued services.

101. How soon can shipping occur for refills?
Answer: For subsequent deliveries of refills, suppliers should deliver the DMEPOS product no sooner than ten calendar days prior to the end of usage for the current product.

102. What documentation must a supplier have in order to meet the request for refill documentation?
Answer: A refill request must include:

- Beneficiary's name or authorized representative if different from 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).

Proof of Delivery

103. If the beneficiary picks up the items in the store, should the delivery address be our store address?
Answer: Yes the store address would be used.

104. If a supplier is mailing items to a beneficiary is it acceptable to send a delivery ticket and a self-addressed stamped envelope along with the items so the beneficiary may sign the delivery ticket showing that they received the items?
Answer: Yes this is an acceptable practice in order to show a valid proof of delivery.

105. When using proof of delivery, method 2, if the receipt clearly states the date of service is the shipping date but the beneficiary signs it several days later due to shipping delays, is the proof of delivery valid?
Answer: Yes, the proof of delivery would be valid to show the items have been received by the beneficiary.

106. When using proof of delivery, method 2, what date should be used when submitting the claim to Medicare for reimbursement?
Answer: When delivering DMEPOS via a shipping service, the date of service on the claim should be the shipping date.

All Other Questions

107. If a beneficiary comes into the shop and asks us to get her prescription for her, is that considered solicitation?

Answer: This is not considered solicitation since contact was made by the beneficiary to the supplier. When the supplier contacts the physician's office they should be clear that the beneficiary has requested for them to contact their physician for an order.

108. Is the prosthesis two year replacement by date of service or by calendar year?
Answer: The replacement timeframe starts the day the prosthesis was delivered to the beneficiary.

109. What does Medicare consider the RUL for the L8000?
Answer: Medicare does not have a RUL specified for the L8000.

110. Are suppliers able to deliver and receive reimbursement when a beneficiary is in a skilled nursing facility?
Answer: For beneficiaries who are currently in a Part A covered stay, within their 100 days, all items/services are considered part of the consolidated billing of the skilled nursing facility. If the 100 days have been exhausted and Medicare Part A has received a claim for "no pay stay" the bras and prostheses can be considered for coverage by the DME MAC.

111. Are suppliers able to charge Medicare or the beneficiary a fitting fee?
Answer: No, suppliers may not charge a fitting fee.

112. Should the mastectomy bra be given and billed the date of surgery?
Answer: The delivery of a mastectomy bra would be dependent upon the beneficiary and their treating physician. Items delivered during a Medicare Part A stay should not be billed to the DME MAC.

113. When are narratives necessary?
Answer: A narrative description is used when providing documentation of a process, measurements, HCPCS codes on a delivery slip etc. there are far too many uses for a narrative description to give all the possible uses. For the claim form the narrative will help to provide information about cause or reason for the item you may have provided; or it may explain the use and reason for a not otherwise classified code. Suppliers will use a narrative on the ABN when applicable.

114. If a beneficiary receives a L8030 and returns to receive a L8020 due to the L8030 is too heavy, will Medicare reimburse on the L8020?
Answer: No, it will deny Same or Similar; the RUL for the L8030 is 2 yrs. The supplier is expected to have properly fit the product prior to delivery. All additional costs for

fitting, adjustments changes etc. that are necessary in the 90 days after delivery are covered by the payment for the original item.

115. Are follow-up phone calls acceptable or must a follow-up be performed in person?
Answer: Proof of continued use and continued medical need are both needed for ongoing supplies or rental items. The specific requirements for each can be found in the LCD and each DME MAC has "dear physician" letters available on their websites that further describe each requirement.

116. How are suppliers notified of future training sessions?
Answer: Each DME MAC posts upcoming trainings (webinars and face-to-face events) via their email listservs in addition to publishing the information on their respective Web sites.

117. When will suppliers be able to use self-service tools to check for same/similar with prosthetic codes?
Answer: This is not currently an option and there is no estimated timeframe whether or when it will become an option.

Correct Coding and Billing for Electronic/ Microprocessor-Controlled Knee (MPK) Systems - February 2013 Revision

Claim reviews demonstrate misunderstanding among suppliers about the correct coding of the various electronic and microprocessor-controlled knee systems. Because not all MPK systems are identical in features and functions the DME MACs are not able to designate a single set of HCPCS Codes to be used for all products. This article will describe the required HCPCS coding for the MPK systems commonly available at this time.

Suppliers often are billing miscellaneous code L5999 (LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE CLASSIFIED) for various elements of microprocessor-controlled knee systems that are considered included in the established code. This use of miscellaneous codes is not correct. For example (not all-inclusive), functions performed by the on-board microprocessors and/or sensors such as "real-time gait assessment," "electronically controlled static stance regulator, adjustable", or the programming necessary for set-up and use of the knee, must not be billed using L5999. There is no separate billing and reimbursement for any other features or functions billed with L5999 since the allowance for all functions and features is included in the payment for codes listed below.

Microprocessor controlled knee systems with swing and stance phase control:

- DAW Industries - SLK
- Endolite - Orion
- Fillauer/Kingsley - REL-K
- Freedom Innovations - Plié
- Otto Bock - C-Leg, Genium, X2

The following HCPCS codes are the only codes billable for the above-listed products or any similar swing and stance phase microprocessor controlled knee system:

- L5828 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
- L5845 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE
- L5848 - ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY
- L5856 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

The following are the only HCPCS codes billable for Ossür Power Knee or any similar swing and stance phase microprocessor controlled knee system with powered and programmable flexion/extension assist:

- L5828 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
- L5845 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE
- L5848 - ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY
- L5856 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
- L5859 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)

The following are the only HCPCS codes billable for Ossür Rheo Knee or any similar swing and stance phase microprocessor controlled knee system with a high activity knee control frame:

- L5828 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
- L5845 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE
- L5848 - ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY
- L5856 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
- L5930 - ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME

The following are the only HCPCS codes billable for Endolite SmartIP or any similar swing phase only microprocessor controlled knee systems

- L5848 - ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY
- L5857 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

The following are the only HCPCS codes billable for Otto Bock C-Leg Compact or any similar stance phase only microprocessor controlled knee system:

- L5828 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
- L5845 - ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE
- L5858 - ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

For any MPK system, the use of additional HCPCS codes other than those specified above, either specific codes or NOC codes, for other add-ons, functions or features is considered unbundling and thus is incorrect coding.

Additional information about coverage, coding and correct billing may be found in the supplier manual, local coverage determinations and on the Pricing, Data Analysis and Coding Contractor (PDAC) web site at www.dmepdac.com.

HCPCS Code L0430 – Invalid

Effective for dates of service on or after November 17, 2012, Healthcare Common Procedure Coding System (HCPCS) code L0430 (SPINAL ORTHOSIS, ANTERIOR-POSTERIOR-LATERAL CONTROL, WITH INTERFACE MATERIAL, CUSTOM FITTED (DEWALL POSTURE PROTECTOR ONLY)) will be invalid for claim submission to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Products previously coded L0430 by the Pricing, Data Analysis and Coding (PDAC) contractor and posted to the Durable Medical Equipment Coding System (DMECS) will be end dated on November 17, 2012. DMECS can be accessed by selecting on the following link, https://www.dmepdac.com/dmecsapp/do/search.

Manufacturers, distributors or suppliers previously billing for L0430 should submit a Coding Verification Review Application to the PDAC to determine the correct billing code.

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

If you have questions, please 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/. Refer to the Spinal Orthosis: TLSO and LSO Local Coverage Determination (LCD) and Policy Articles (PA) for additional coverage, coding and documentation requirements.

HCPCS L5980, L5981, and L5987 – Notification of Widespread Prepayment Probe Review

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

HCPCS	Description
L5980	Lower extremity prosthesis, Foot flex system
L5981	Lower extremity prosthesis, Flex-walk system or equal
L5987	Lower extremity prosthesis, shank foot system with vertical loading pylon

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

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

- Treating physician's dispensing and written order; and,
- Documentation of dispensing order (if item is dispensed based on dispensing order); and,
- Patient's medical records (physician medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) that support the item (s) provided are reasonable and necessary; and,
- Documentation to support the functional level modifier used; and,
- Proof of delivery of item (s) ordered; and,
- The Advanced Beneficiary Notice (if applicable); and,
- Any other supporting documentation.

Failure to supply the above requested information within **45 days** of the date on the letter will result in the claim being denied. Please fax requested documentation and a copy of the ADR letter to 1-701-277-7888 or mail to Noridian 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 Lower Limb Prostheses Local Coverage Determination (LCD) L11453 and Policy Article A25367.

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

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

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes L4360, L1970 and L1960. This review was initiated based on CERT analysis.

- The L4360 review involved 101 claims of which 97 were denied. This resulted in an overall error rate of 97%.
- The L1970 review involved 100 claims of which 80 were denied. This resulted in an overall error rate of 79%.
- The L1960 review involved 100 claims of which 69 were denied. This resulted in an overall error rate of 68%.

Primary Documentation Errors that Resulted in Denial of Claims

- 21% of L4360 claims received a denial as basic coverage criteria not met.
- 21% of L1970 claims received a denial as basic coverage criteria not met.
- 30% of L1960 claims received a denial as basic coverage criteria not met.

Medical Records Insufficient to Support Basic Coverage Criteria
BASIC COVERAGE CRITERIA: Ankle-foot orthoses 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.

- 21% of L1970 claims received a denial as criteria 1,2,3,4 or 5 not met.
- 32% of L1960 claims received a denial as criteria 1,2,3,4 or 5 not met.

1 of the 5 following criteria were not met:

- The beneficiary could not be fit with a prefabricated AFO; or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or,
- There is a need to control the knee, ankle or foot in more than one plane; or
- The beneficiary has a documented neurological, circulatory or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
- The beneficiary has a healing fracture which lacks normal anatomic integrity or anthropometric proportions.
- 20% of L4360 claims received a denial as no proof of delivery submitted.
- 7% of L1960 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.

- 42% of L4360 claims received a denial as no written or verbal order received.
- 7% of L1970 claims received a denial as no written or verbal order received.
- 5% of L1960 claims received a denial as no written or verbal order received.

No Written or Verbal 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

Going Forward
Based on high error rate, Noridian Administration Services will close this probe review and begin a widespread targeted review on HCPCS codes L4360, L1970 and L1960.

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

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#tools.

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

Results of Widespread Prepayment Probe Review of Spinal Orthoses (HCPCS L0631 and L0637)

Review Results
Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes L0631 and L0637. This review was initiated based on reason for review by CERT analysis.

- The L0631 review involved 101 claims of which 96 were denied. This resulted in an overall error rate of 96%.
- The L0637 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

- 24% of L0631 claims received a denial as Criteria 1 not met.
- 14% of L0637 claims received a denial as Criteria 1 not met.

The beneficiary's medical records did not *indicate* the LSO order as reasonable and medically necessary as described in LCD 11459.

A lumbar-sacral orthosis is covered when it is ordered for one of the following indications:

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

- 23% of L0631 claims received a denial as documentation does not support medical necessity for the item requested.
- 13% of L0637 claims received a denial as documentation does not support medical necessity for the item requested.

The beneficiary's medical records did not *justify* the LSO as medically reasonable and necessary.

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

- Beneficiary's medical record submitted does not have sufficient objective documentation to validate beneficiary use of a LSO as reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member.
- According to the supplier manual the provision of an identical or nearly identical item may be replaced when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item. The useful lifetime of a spinal orthosis is no less than 5 years. Medical record documentation must validate the need for a new or replaced spinal orthosis.
- 14% of L0637 claims received a denial as *no proof of delivery* submitted.
- 7% of L0631 claims received a denial as *invalid proof of delivery*.

L0637 – 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.

L0631 – Requirements for proof of delivery.
Delivery Directly to Beneficiary
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.

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

- 12% of L0631 claims received a denial as no documentation 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.

- 12% of L0637 claims received a denial as billing requirements not met.

Billing Requirements
Part A Covered SNF or Hospital Stay

- Payment for spinal orthosis is included in payment to hospital or SNF if:
  1. The orthosis is provided to a patient *prior* to an inpatient hospital admission or Part A covered SNF stay; **and**
  2. Medical necessity for the orthosis begins during the hospital or SNF stay (e.g., after spinal surgery).
- Or:
  1. Orthosis is provided to a patient *during* an inpatient hospital or Part A covered SNF stay prior to the day of discharge; and
  2. Patient uses the item for medically necessary inpatient treatment or rehabilitation.

DME MAC Submitted Claim

- Payment for spinal orthosis delivered to patient in hospital or Part A covered SNF stay *is* eligible for coverage by DME MAC if:
  1. The orthosis is medically necessary for a patient after discharge from a hospital or Part A covered SNF stay; and
  2. The orthosis is provided to the patient within two days prior to discharge home; and
  3. The orthosis is not needed for inpatient treatment or rehabilitation, but is left in the room for the patient to take home.

Going Forward
Based on high error rate, Noridian Administration Services will close this probe review and begin a widespread targeted review on HCPCS codes L0631 and L0637.

Education Resources
It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthosis Local Coverage Determination (LCD) L11459 https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_lcds/spinal_orthoses_tlso_and_lso.htm and Policy Article A23846 https://www.noridianmedicare.com/dme/coverage/docs/lcds/current_articles/spinal_orthoses_tlso_and_lso.htm.

Noridian 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

Revised - Coding Guidelines for Ankle Foot Orthoses

Consistent with the revision of the DME MAC Local Coverage Article for Ankle-Foot/Knee-Ankle-Foot Orthoses - Policy Article - Effective January 1, 2013, the Pricing Data Analysis & Coding (PDAC) contractor has revised the definition for L1960 from when this article was originally published in December 2011. Please Note: The reference to a specific measurement for the height of a L1960 AFO has been removed.

All other guidelines published when this article was posted to the PDAC website on December 21, 2011 remain in effect. These guidelines are intended to provide further definition and clarification for certain orthoses and assist suppliers in correct coding of these devices.

L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL
A pre-tibial shell, custom fabricated, provides a rigid overlapping interlocking anterior tibial control between the tibial tuberosity to a point no greater than 3 inches proximal to the medial malleolus. The pre-tibial shell can be constructed from thermosetting materials, thermoplastics, or composite type materials.

L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT
A multiligamentous ankle support provides control of the ankle joint between the medial and lateral malleoli while allowing for dorsiflexion and plantar flexion. This off-the-shelf ankle support includes a rigid stirrup and foot plate which provides functional tracking of the ankle with hind-foot and mid-foot stability during ambulation. This, in conjunction with wrap-around straps and the inherent gauntlet design, offers areas of multiligamentous support as described by the code. There are no additional HCPCS codes for this type of prefabricated ankle orthosis.

L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED
An Ankle Foot Orthosis (AFO) provides ankle control for patients with musculoskeletal or neuromuscular dysfunction. The AFO is designed to provide rigid immobilization of the ankle-foot complex in the sagittal, coronal, and transverse planes. The custom fabricated solid ankle AFO can be constructed from thermosetting materials, thermoplastics, or composite type materials.

Effective for claims with dates of service on or after April 1, 2012, the only products which may be billed to Medicare using code L1906 (ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT) are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS) maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code A9270.

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/.

Results of Widespread Prepayment Probe Review of External Breast Prostheses (HCPCS L8030)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS code L8030. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

- The L8030 review involved 95 claims of which 68 were denied. This resulted in an overall error rate of 76%.

Primary Documentation Errors that Resulted in Denial of Claims

- 22% 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.

- 19% of L8030 claims received a denial as documentation submitted did not support medical necessity for the item requested.

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

A breast prosthesis is covered for a patient who has had a mastectomy, ICD-9-CM diagnosis codes V10.3, V45.71, 174.0-174.9, 198.81, 233.0, or 457.0.

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.

- 17% 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.

- 14% of L8030 claims received a denial as no documentation was received.

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

ORTHOTICS AND PROSHETICS CONT'D

Going Forward
Based on high error rate, Noridian Administration Services will close this probe review and begin a widespread targeted review on HCPCS code L8030.

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 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.

OVERPAYMENTS/REFUNDS

Refunds to Medicare

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

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

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

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

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

OXYGEN

Breathe NIOV™ – Coding Reminder – E1399 – DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

The Non-invasive OPEN Ventilation System (NIOV™) by Breathe Technologies, Inc. provides positive pressure inspiratory support for patients using oxygen. The correct HCPCS code to use for billing this item is:

- E1399 – DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

Based on clinical data provided by the manufacturer, this item is effective only when used in conjunction with oxygen; therefore, it is classified as an accessory to oxygen equipment. Oxygen reimbursement is a bundled payment. All options, supplies and accessories are considered included in the monthly rental payment.

Note: Numerous sources, including the manufacturer materials and references in published clinical articles, use the term "ventilator" when discussing this device. For Medicare payment purposes, the NIOV™ device is NOT considered to be a ventilator or any other type of positive airway pressure device (CPAP, bi-level PAP, etc.). DMEPOS suppliers must not use HCPCS codes assigned to those products when submitting claims for the NIOV™ device.

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination and related Policy Article for additional information about documentation, coverage and coding requirements.

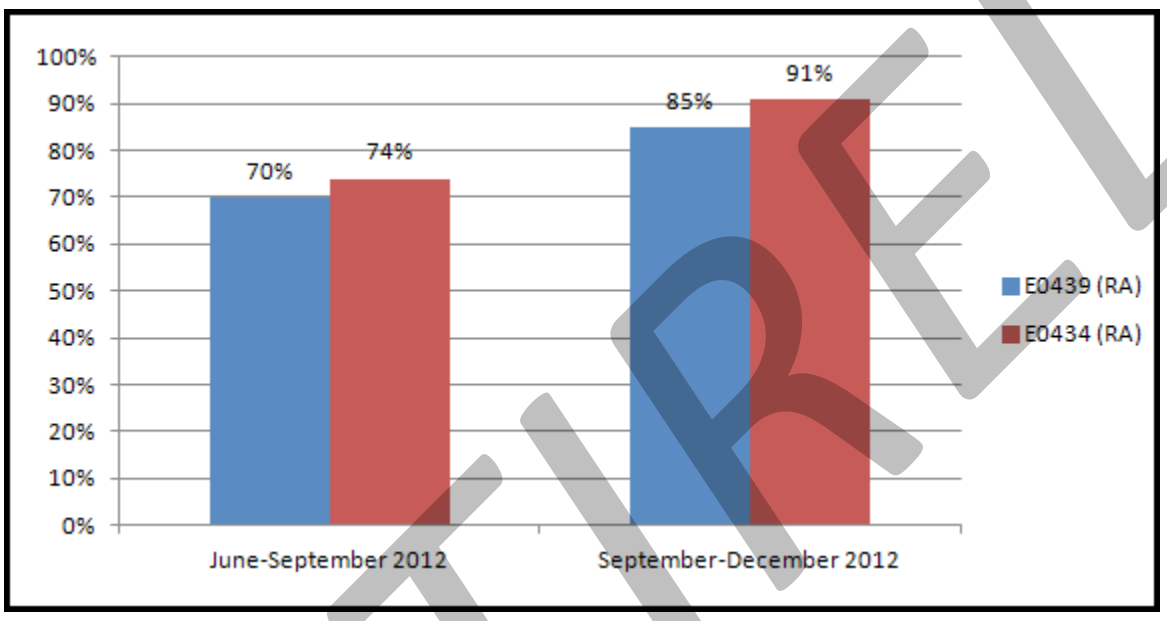
Second Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment Billed With the RA Modifier (HCPCS E0439 and E0434)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0439 and E0434 billed with the RA modifier. The second quarter edit effectiveness results from September 2012 through December 2012 are as follows:

- The E0439 (RA) review involved 41 claims of which 34 were denied. This resulted in an overall error rate of 85%.
- The E0434 (RA) review involved 46 claims of which 40 were denied. This resulted in an overall error rate of 91%.

Historical Data of the Error Rate for E0439 (RA) and E0434 (RA) Review



Primary Documentation Errors that Resulted in Denial of Claims

- 41% of E0439 (RA) claims received a denial as no documentation was received.
- 35% of E0434 (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.

- 14% of E0439 (RA) claims received a denial as no documentation was provided to support continued use.
- 13% of E0434 (RA) claims received a denial as no documentation was provided to support continued use.

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.

OXYGEN CONT'D

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

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

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

- 12% of E0439 (RA) claims received a denial as no documentation was provided to support the blood gas study documented on the CMN.
- 17% of E0434 (RA) claims received a denial as no 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).

- 10% of E0439 (RA) claims received a denial as no documentation was submitted to support continued need.
- 13% of E0434 (RA) claims received a denial as no documentation was submitted to support continued need.

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

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

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

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

Going Forward
Based on 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 Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677.

OXYGEN CONT'D

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/oxygen_and_oxygen_equipment.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian 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.

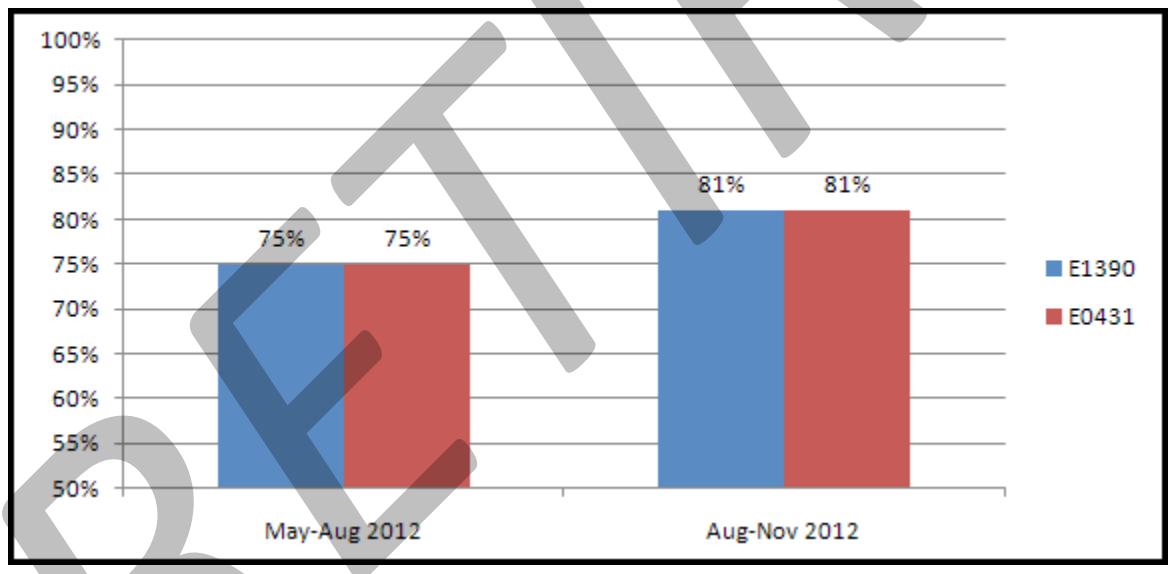
Second Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment billed with RA Modifier (HCPCS E1390 and E0431)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E1390 and E0431. The second quarter edit effectiveness results from August 2012 through November 2012 are as follows:

- The E1390 (with the RA modifier) review involved 391 claims of which 286 were denied. This resulted in an overall error rate of 75%.
- The E0431 (with the RA modifier) review involved 137 claims of which 107 were denied. This resulted in an overall error rate of 81%.

Historical Data of the Error Rate for E1390 (RA) and E0431 (RA) Review



Primary Documentation Errors that Resulted in Denial of Claims

- 23% of E1390 (RA) claims received a denial as no documentation was provided to support the continued need of oxygen.
- 24% of E0431 (RA) claims received a denial as no documentation was submitted 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.

OXYGEN CONT'D

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.

- 24% of E1390 (RA) claims received a denial as no documentation was provided to support continued use of oxygen.
- 23% 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.

- 11% 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).
- 9% of E1390 (RA) claims received a denial as no documentation was received.
- 10% 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.

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 Oxygen and Oxygen Equipment Local Coverage Determination Local Coverage Determination (LCD) L11457 and Policy Article A33677

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the NAS website at: https://www.noridianmedicare.com/dme/coverage/resources/oxygen_and_oxygen_equipment.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian 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#tools.

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

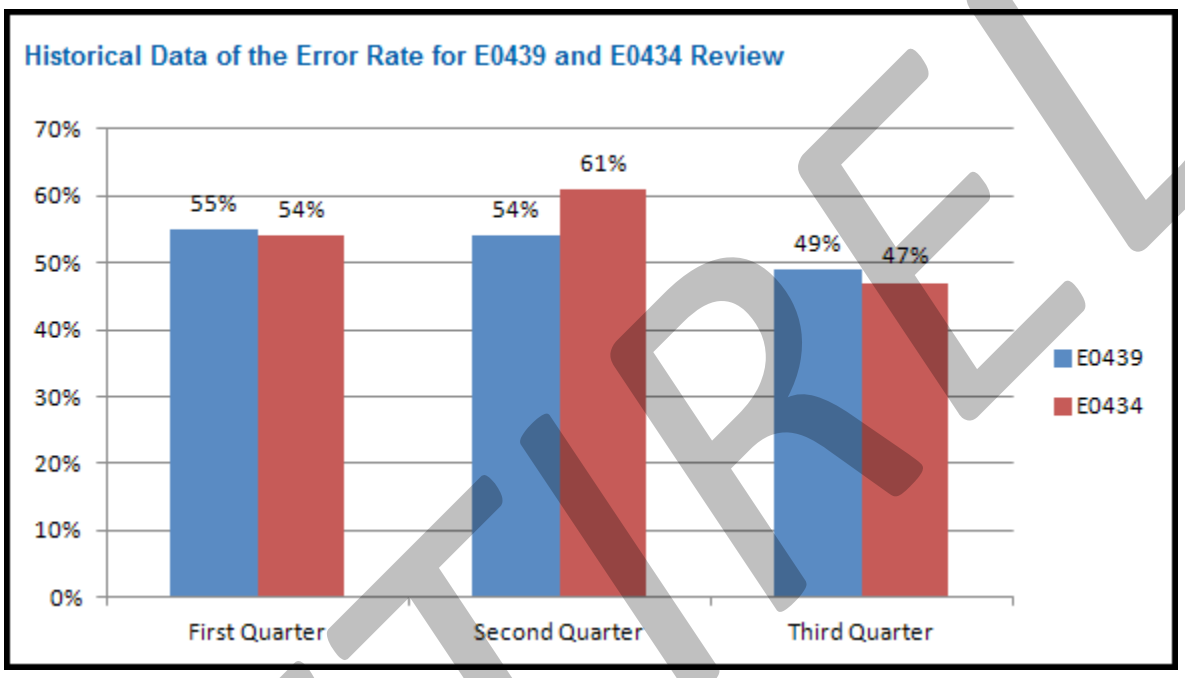
Third Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS E0439 and E0434)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0439 and E0434. The third quarter edit effectiveness results from October 2012 to January 2013 are as follows:

- The E0439 review involved 326 claims of which 154 were denied. This resulted in an overall error rate of 49%.
- The E0434 review involved 173 claims of which 80 were denied. This resulted in an overall error rate of 47%.

Historical Data of the Error Rate for E0439 and E0434 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 20% of E0439 claims received a denial as no documentation was provided to support that the patient was seen and evaluated by the treating physician within 30 days prior to initial certification.
- 24% of E0434 claims received a denial as no documentation was provided to support that the patient was seen and evaluated by the treating physician within 30 days prior to initial certification.

The beneficiary must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification.

An evaluation by the treating physician, within 30 days prior to initial certification, is required when the CMN is initiated in the following instances:

- With the first claim for home oxygen, (even if the beneficiary was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO.)
- During the first 36 months of the rental period, when there has been a change in the beneficiary's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. (Please refer to the Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES for additional information.)
- 17% of E0439 claims received a denial as no medical documentation was provided to support that alternative treatment measures have been tried or considered and deemed clinically ineffective.
- 13% of E0434 claims received a denial as no medical documentation was provided to support that alternative treatment measures have been tried or considered and deemed clinically ineffective.

OXYGEN CONT'D

Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated below, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

- 12% of E0439 claims received a denial as no documentation was provided to support that the treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
- 11% of E0434 claims received a denial as no documentation was provided to support that the treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.

Medical documentation must support that the treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.

- 10% of E0439 claims received a denial as no documentation was received.
- 14% of E0434 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 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 Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677.

Suppliers can also review specific policy resources for Oxygen and Oxygen Equipment on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/oxygen_and_oxygen_equipment.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian 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

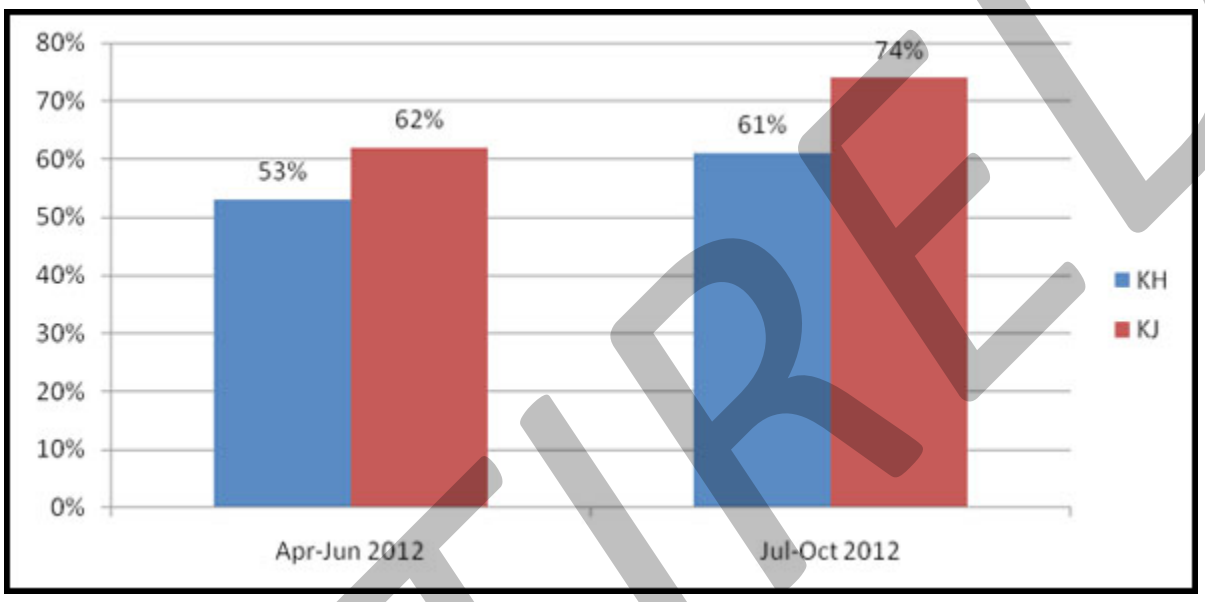
Second Quarter Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (HCPCS E0601)

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 second quarter edit effectiveness results from July 2012 through October 2012 are as follows:

- The KH modifier review involved 2172 claims of which 1338 were denied. This resulted in an overall error rate of 62%.
- The KJ modifier review involved 1941 claims of which 1406 were denied. This resulted in an overall error rate of 74%.

Historical Data of the Error Rate for KH Modifier and KJ Modifier Review



Primary Documentation Errors that Resulted in Denial of Claims

- 17% of KH claims received a denial as Criterion A was not met.
- 13% of KJ claims received a denial as Criterion A was not met.

The patient has 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)

- 12% of KH claims received a denial as signature requirements were not met.
- 9% of KJ claims received a denial as signature requirements were not met.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author per PIM 3.3.2.4. Stamped signatures are not accepted.

- 10% of KH claims received a denial as Criterion B was not met.

The patient has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

- The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
- The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
  - Hypertension, ischemic heart disease, or history of stroke.
- 10% of KH claims received a denial as no documentation was received within the timeframe allowed per Medicare guidelines.
- 7% of KJ claims received a denial as no documentation was received within the timeframe allowed per Medicare guidelines.

PAP DEVICES CONT'D

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 KJ claims received a denial as criterion one was not met for continued coverage beyond the 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:

1. Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved;

- 13% of KJ claims received a denial as criterion two 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:

1. Objective evidence of adherence to use of the PAP device reviewed by the treating physician.

Adherence to therapy is defined as use of PAP = 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

Reminder Regarding Home Sleep Test
Claims submitted with a Home Sleep Test were denied in both KH and KJ reviews for lack of HST instruction specific to the beneficiary of the claim. As a reminder, the Local Coverage Determination (LCD) Continuous Positive Airway Pressure Devices (L171) states in part: "For all PAP devices, beneficiaries who undergo an HST must, prior to having the test, receive instruction on how to properly apply a portable sleep monitoring device. This instruction must be provided by the entity conducting the HST and may not be performed by a DME supplier. Patient instruction may be accomplished by either: Face-to-face demonstration of the portable sleep monitoring device's application and use; or, Video or telephonic instruction, with 24 hour availability of qualified personnel to answer questions or troubleshoot issues with the device."

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 NAS 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#tools.

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

HCPCS Code Update – 2013

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2013.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2013.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2012, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2013.

There is no grace period that would allow submission of the discontinued code for dates of service in 2013.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2013.

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

External Breast Prostheses

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L8000	BREAST PROSTHESIS, MASTECTOMY BRA	BREAST PROSTHESIS, MASTECTOMY BRA, WITHOUT INTEGRATED BREAST PROSTHESIS FORM, ANY SIZE, ANY TYPE
L8001	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, UNILATERAL	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, UNILATERAL, ANY SIZE, ANY TYPE
L8002	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, BILATERAL	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, BILATERAL, ANY SIZE, ANY TYPE

Hospital Beds and Accessories

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
E0300	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED, WITH OR WITHOUT TOP ENCLOSURE

Immunosuppressive Drugs

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
J8561	EVEROLIMUS, ORAL, 0. 25 MG	J7527

Added Code	
Code	**Narrative**
J7527	EVEROLIMUS, ORAL, 0. 25 MG

Impotence Aid

Added Code	
Code	**Narrative**
L7902	TENSION RING, FOR VACUUM ERECTION DEVICE, ANY TYPE, REPLACEMENT ONLY, EACH

Intravenous Immune Globulin

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX/ GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E. G. LIQUID), 500 MG
J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), NON-LYOPHILIZED, (E. G. LIQUID), 500 MG

Lower Limb Prostheses

Added Code	
Code	**Narrative**
L5859	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L5972	ALL LOWER EXTREMITY PROSTHESES, FLEXIBLE KEEL FOOT (SAFE, STEN, BOCK DYNAMIC OR EQUAL)	ALL LOWER EXTREMITY PROSTHESES, FOOT, FLEXIBLE KEEL

Ostomy Supplies

Added Code	
Code	**Narrative**
A4435	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, WITH EXTENDED WEAR BARRIER (ONE-PIECE SYSTEM), WITH OR WITHOUT FILTER, EACH

Oxygen and Oxygen Equipment

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
K0741	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL, INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING, FOR CLUSTER HEADACHES	NONE
K0742	PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT, FOR CLUSTER HEADACHES, FOR INITIAL MONTHS SUPPLY OR TO REPLACE USED CONTENTS	NONE

Pneumatic Compression Devices

Added Code	
Code	**Narrative**
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK

Surgical Dressings

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
A6021	COLLAGEN DRESSING, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH	COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH
A6022	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN. , EACH
A6023	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 48 SQ. IN. , EACH

Wheelchair Options/Accessories

Added Code	
Code	**Narrative**
E2378	POWER WHEELCHAIR COMPONENT, ACTUATOR, REPLACEMENT ONLY

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR, ANY TYPE
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL MOTOR, REPLACEMENT ONLY
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL GEAR BOX, REPLACEMENT ONLY
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	POWER WHEELCHAIR COMPONENT, INTEGRATED DRIVE WHEEL MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY

Items Requiring Coding Verification Reviews by PDAC

This article has been updated as it inadvertently contained codes under the ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS section that should not have been included.

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 web site 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.

PDAC CONT'D

CODE		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
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	3/1/13
NEGATIVE PRESSURE WWOUND THERAPY PUMPS		
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	1/1/06

PDAC CONT'D

CODE		EFFECTIVE DATE
NEBULIZERS E0574 (EFFECTIVE 4/1/11)		
E0574	ULTRASONIC GENERATOR W SVNEB	4/1/11
ORAL APPLIANCES		
E0486	ORAL DEVICE/APPLIANCE CUSFAB	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
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

PDAC CONT'D

CODE		EFFECTIVE DATE
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
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

PDAC CONT'D

CODE		EFFECTIVE DATE
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
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

PDAC CONT'D

CODE		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
K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA	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		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

PDAC CONT'D

CODE		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

PDAC CONT'D

CODE		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

PDAC CONT'D

CODE		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

PDAC CONT'D

CODE		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
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

PDAC CONT'D

CODE		EFFECTIVE DATE
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
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

CODE		EFFECTIVE DATE
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
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

PDAC CONT'D

CODE		EFFECTIVE DATE
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

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers

MLN Matters® Number: SE1201 Revised

Note: This article was revised on December 13, 2012, to add clarifying language to the bullet point at the top of page 3 related to optometrists. All other information remains the same.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual National Provider Identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background
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.

MLN Matters® Special Edition Articles SE1011 and SE1221 provide further details about edits on the ordering/referring provider information on claims. SE1011 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf and SE1212 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf on the CMS website.

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.

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.

Phase 2 of Ordering/Referring Requirement

MLN Matters® Number: SE1221

Note: This article was revised on December 10, 2012, to delete language from pages 2 and 4 relating to portable x-ray services. All other information remains the same.

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) 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 RHHIs, Fiscal Intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Provider Action Needed
CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the Ordering/Referring Provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60 day advanced notice prior to turning on the Ordering/Referring edits. CMS does not have a date at this time.

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with Phase 2 Ordering/Referring edits. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

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).

Background
The Affordable Care Act requires physicians or other eligible professionals to be enrolled in the Medicare Program to order/ refer items or services for Medicare beneficiaries. 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).

CMS began expanding the claims editing to meet these requirements for ordering and referring providers as follows:

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

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:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
- Physician Assistant,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,
- Interns, Residents, and Fellows
- Certified Nurse Midwife, and
- Clinical Social Worker.

The informational message will indicate 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 does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

PECOS CONT'D

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

Phase 2: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will 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 be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

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

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," on April 24, 2012, permitting Phase 2 edits to be implemented.

PECOS CONT'D

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement Phase 2 edits.

Additional Information
A note on 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. CMS has used this term on its website and in educational products. 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 for 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.

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® fact sheet, "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and 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.

You may find the following articles helpful in understanding this matter:

- 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.

PRESSURE REDUCING SUPPORT SURFACES

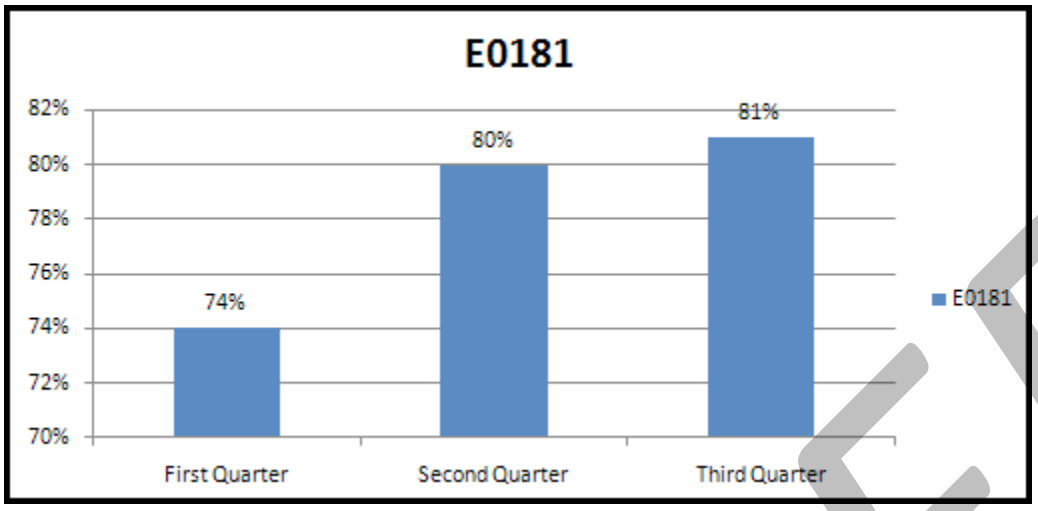
Third Quarter Results of Widespread Prepayment Review of Claims for Group I Pressure Reducing Support Surfaces (HCPCS E0181)

Current Review Results
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0181. The third quarter edit effectiveness results from October 2012 through January 2013 are as follows:

- The E0181 review involved 516 claims of which 416 were denied. This resulted in an overall error rate of 81%.

PRESSURE REDUCING SUPPORT SURFACES CONT'D

Historical Data of the Error Rate for E0181 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 28% of E0181 claims received a denial as Criteria 1, 2 and/or 3 not met.

A group 1 mattress overlay or mattress is covered if one of the following three criteria are met:

- The patient is completely immobile-i.e., patient cannot make changes in body position without assistance, or
- The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
- The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D.
- 22% of E0181 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.

- 14% of E0181 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 E0181 claims received a denial as proof of delivery dated prior to the date of service of the claim.

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

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

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 1 Pressure Reducing Support Surfaces Local Coverage Determination (LCD) L11578 and Policy Article A33678.

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

Widespread Prepayment Review for E0181 Group 1 Pressure Reducing Support Surfaces- Edit Effectiveness for Second Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0181 and the second quarter edit effectiveness results from July 27, 2012 through October 26, 2012 are as follows:

The results of the review, for item E0181, identified 352 claims of which 276 were denied. 55 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 80%. Total dollars allowed were $2,179.42; total dollars denied were $8,582.35.

Due to the high error rate, NAS will continue with the widespread complex review for the E0181.

The following are the top reasons for denial:

1. Criteria 1, 2, and or 3 of LCD L11578 were not met.
2. Order not properly completed.
3. No documentation received.
4. Conditions A-D not met for criteria 2 and 3 of LCD L11578.

An in depth explanation of the denial reasons are as follows:

A. Per LCD L11578, 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 below.

   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

B. 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 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.

C. Per LCD L11578, 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. 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.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces Group 1 LCD L11578 and Policy Article A33678 and Supplier's Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html

Widespread Prepayment Review for E0185 Group 1 Pressure Reducing Support Surface- Edit Effectiveness for Second Quarter

The jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0185. The second quarter edit effectiveness results from August 3, 2012 through November 2, 2012 are as follows:

The results of the review, for item E0185, identified 604 claims of which 482 were denied. 89 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 80%. Total dollars allowed were $39,273.53; total dollars denied were $153,632.65.

Due to the high error rate, NAS will continue with the widespread complex review for the E0185.

The following are the top reasons for denial:

1. Criterion 1, 2, and or 3 of LCD L11578 were not met.
2. Conditions A-D for criterion 2 and 3 of LCD L11578 were not met.
3. No documentation received.
4. Order not properly completed.

An in-depth explanation of the denial reasons are as follows:

A. Per LCD L11578, 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 below.

   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

B. Per LCD L11578, 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. 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.

C. 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 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.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces Group 1 LCD L11578 and Policy Article A33678 and Supplier's Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html

Widespread Prepayment Review for E0277 Group 2 Pressure Reducing Support Surface-Edit Effectiveness for Second Quarter

The jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0277. The second quarter edit effectiveness results from August 3, 2012 - November 2, 2012 are as follows:

The results of the review, for item E0277, identified 250 claims of which 180 were denied. 58 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 75%. Total dollars allowed were $43,988.65; total dollars denied were $129,425.25.

Due to the high error rate, NAS will continue with the widespread complex review for the E0277.

The following are the top reasons for denial:

1. Criterion 1 and 2 and 3 of LCD L11579 were not met.
2. Criterion 4 of LCD L11579 not met.
3. Criterion 5 and 6 not met.
4. No documentation received.

An in-depth explanation of the denial reasons are as follows:

A. Per LCD L11579, 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).

B. Per LCD L11578, 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. 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.

REMITTANCE ADVICE

MREP Enhancement

MLN Matters® Number: MM8149
Related Change Request (CR) #: CR 8149
Related CR Release Date: January 18, 2013
Related CR Transmittal #: R1163OTN
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers who use Medicare Remit Easy Print (MREP) software.

What You Need To Know
Change Request (CR) 8149, from which this article is taken, instructs the relevant Medicare contractor, Viable Information Processing Systems (ViPS), to add an enhancement to Medicare Remit Easy Print (MREP) software so that it is compatible with additional personal computer operating systems.

Background
The Centers for Medicare & Medicaid Services (CMS) offers free software (Medicare Remit Easy Print (MREP)) to view and print HIPAA compliant Electronic Remittance Advice (Transaction 835 - Health Care Claim Payment/ Advice). CMS believes that making the software compatible with multiple operating systems would make it more acceptable to users and providers/suppliers and help the transition from paper to Electronic Remittance Advice (ERA).

Therefore, as part of the regular software enhancement process (designed to meet the changing needs of providers/suppliers to help you transition to ERA), CR7218 (published on November 12, 2010) instructed ViPS to make the MREP compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems. (You can find the related MLN Matters® article, MM7218 (Medicare Remit Easy Print (MREP) Enhancement), at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7218.pdf on the CMS website.)

In response to reports of user issues with MREP, CR8149, from which this article is taken, instructs ViPS to analyze and resolve (effective July 1, 2013) the finding that a ".NET Framework is required by MREP but is incompatible with Windows 7."

Your carrier, B MAC, or DME MAC will notify you (effective July 1, 2013) of the enhancement in MREP software once the resolutions are implemented.

Additional Information
The official instruction, CR8149, issued to your carrier, B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1163OTN.pdf on the CMS website.

Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update

MLN Matters® Number: MM8154
Related Change Request (CR) #: CR 8154
Related CR Release Date: December 21, 2012
Related CR Transmittal #: R2618CP
Effective Date: April 1, 2013
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 (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) 8154 which instructs Medicare contractors and Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been added since the last recurring code update. It also instructs Medicare System maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA; see http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf on the Internet), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in Remittance Advice (RA) and Coordination of Benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper Remittance Advice (RA), there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

The CARC and RARC changes that impact 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, then 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.

Medicare contractors stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR8154, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only 3 times a year and may not match the CMS schedule for releasing its system updates.

CR8154 lists only the changes that have been approved since the last code update CR (CR 8029, Transmittal 2521, issued on August 17, 2012), and does not provide a complete list of codes for these two code sets.

The WPC website (see http://www.wpc-edi.com/Reference) has four listings available of Codes by Status for both CARC and RARC.

1. **Show All:** All codes including current, to be deactivated and deactivated codes are included in this listing.
2. **Current:** Only currently valid codes are included in this listing.
3. **To Be Deactivated:** Only codes to be deactivated at a future date are included in this listing.
4. **Deactivated:** Only codes with prior deactivation effective dates are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented.

The CARC and RARC changes reflected by CR8154 are as follows:

REMITTANCE ADVICE CONT'D

New Codes – CARC:

Code	Code Narrative	Effective Date
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	9/30/2012
245	Provider performance program withhold.	9/30/2012
246	This non-payable code is for required reporting only.	9/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*	9/30/2012
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*	9/30/2012
249	This claim has been identified as a resubmission. (Use only with Group Code CO)	9/30/2012
250	The attachment content received is inconsistent with the expected content.	9/30/2012
251	The attachment content received did not contain the content required to process this claim or service	9/30/2012
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9/30/2012
W3	The Benefit for this Service is included in the payment/allowance for another service/ procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	9/30/2012
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	9/30/2012
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.	9/30/2012

REMITTANCE ADVICE CONT'D

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
18	Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)	1/1/2013
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	9/30/2012
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	9/30/2012
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. (Use only with Group Code OA)	9/30/2012
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	7/1/2013
173	Service was not prescribed by a physician. This change effective 7/1/2013: Service/ equipment was not prescribed by a physician.	7/1/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	7/1/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	7/1/2013
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	9/30/2012
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	9/30/2012
221	Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	9/30/2012

Code	Modified Narrative	Effective Date
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	7/1/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	7/1/2013
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee	7/1/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	7/1/2013

Deactivated Codes – CARC: None

New Codes – RARC :

Code	Code Narrative	Effective Date
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.	11/1/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.	11/1/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	11/1/2012
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	11/1/2012
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	11/1/2012
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.	11/1/2012
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.	11/1/2012

REMITTANCE ADVICE CONT'D

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
M39	The Note: (Modified 2/1/04, 4/1/07, 11/1/09) Related to N563	11/1/2012
M137	Part B coinsurance under a demonstration project or pilot program.	11/1/2012

Deactivated Codes – RARC:

Code	Narrative	Effective Date
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	11/1/2012

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the Business Requirements segment of CR8154 for an explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional Information
The official instruction, CR8154 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2618CP.pdf on the CMS website. For more information on CARC and RARC codes go to http://www.wpc-edi.com/Reference on the internet.

RESPIRATORY ASSIST DEVICES

Notification of Prepayment Review for Respiratory Assistive Device HCPCS Codes

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

- **E0470** – RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)
- **E0471** - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) and related Policy Articles for the HCPCS listed in this notification article:

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (Formerly CPAP): L171 & A19827
- Respiratory Assistive Devices: RAD L11493 & A23902
- 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

SELF-SERVICE

Consolidated Resource Pages: Documentation, TENS, Nebulizers, Repairs and Replacements

Four additional consolidated resource pages have been added to the NAS DME website: Documentation, Transcutaneous Electrical Nerve Stimulators (TENS), Nebulizers, and Repairs and Replacements. These policy-specific pages contain coverage information, educational guides, review/audit resources, and publications.

The TENS and Nebulizers consolidated resource pages are accessible two ways:

1. Current Local Coverage Determination (LCD) page: https://www.noridianmedicare.com/dme/coverage/lcd.html
   a. Control + F to find the policy or scroll down the page
   b. Consolidated Resources is located below the LCD and Policy Article identification number.
2. Training and Events page: https://www.noridianmedicare.com/dme/train/
   a. Control + F to find the policy or scroll down the page
   b. Consolidated Resources is located under the Workshop Material/Q&A/Tutorials column

The Documentation and Repairs and Replacements pages are only accessible from the Training and Events page.

DME Website Satisfaction Survey – Your Feedback is Important and Heard!

Visitors to the NAS DME website, www.noridianmedicare.com/dme, have an opportunity to complete a "Website Satisfaction Survey" randomly presented as visitors navigate the website. NAS evaluates all input received from this survey. The feedback you provide helps NAS improve and enhance our website and help us serve our supplier community better.

Those who participate and complete the survey will not see the survey again for 30 days. If you have responded to the survey previously, we would appreciate any new comments you have regarding the changes implemented since your last survey responses; feel free to take the survey more than once.

The survey is the result of the Centers for Medicare & Medicaid Services contract with Foresee Results, an independent third party survey company, to assess the effectiveness of Medicare contractor websites. All survey results are strictly confidential. NAS is provided only with the statistical survey results and comments; not visitor information.

NAS highly values your feedback and suggestions. We greatly appreciate the time you invested in taking the survey and providing your feedback.

Free, Online DME Supplier Portal (Endeavor) Reminders

NAS DME provides Endeavor users with reminders regarding protecting your assigned account, entering search criteria, and accessing the portal to obtain eligibility, claim status, overpayment details, appeal status and submission, same or similar equipment, and claim-specific remittance advices.

Do Not Share User IDs
Do not share your User ID and password with others. Each person accessing Endeavor must register for their own User ID. If Endeavor Support discovers User IDs are shared within a company, access may be permanently disabled.

Adding NPIs
When adding NPIs to an existing account, the NPIs are not automatically added. These requests must be processed by Endeavor Support prior to being added.

Do Not Use Bookmarks, Favorites or Shortcuts
If a supplier accesses Endeavor by a bookmark, favorite or shortcut, it will cause the account to lock. The most efficient way of accessing Endeavor is by saving the DME homepage, https://www.noridianmedicare.com/dme, and selecting Log In/Register in the right column.

Same or Similar Inquiries
When inquiring on same or similar, be sure to verify the HCPCS code is tracked for same or similar by reviewing the Same or Similar Reference Chart. HCPCS codes beginning with G, J, L, Q, and V are not tracked for same or similar. Also, the only HCPCS code beginning with A that is tracked is A4600. Our records indicate suppliers are attempting to check same or similar on codes that are not tracked.

When entering the HCPCS code, be sure to include RR or NU modifier, if applicable. To determine if the RR or NU is required in Endeavor, see the fee schedule on our website at https://www.noridianmedicare.com/dme/fees/dmepos.html. If the HCPCS code shows the RR or NU modifier in the "Mod" column, it is required in Endeavor. If the modifier is not entered, the error message will state that the item is not tracked for same or similar.

Entering Patient Information
Ensure there are no extra spaces after entering the beneficiary information. When extra spaces are entered after the beneficiary's Medicare number, Endeavor will display an error message stating "HICN: The value entered contains invalid characters." If extra spaces are entered after the beneficiary's name in claim status, Endeavor will display a message stating "No records match the Health Insurance Claim Number (HICN)."

If a beneficiary has two last names or a hyphenated last name, enter the two names with a space between them. For example, Doe-Smith is entered as Doe Smith.

Password Resets and Locked Accounts
DME suppliers are reminded to email dmeendeavor@noridian.com for assistance with resetting passwords and unlocking accounts.

Is your account up-to-date?
Suppliers should ensure their email address and fax number is accurate on his/her account. To check this information:

1. Under Admin Options in the left column select Change Password.
2. In the left column, select Edit Profile.
3. Make necessary changes and select Save.

Share Your Thoughts
Let us know your thoughts on Endeavor. There is a survey link in the footer of every Endeavor page. This survey is different than our website surveys. We value your feedback!

Additional Information
For more information on Endeavor, see our website at https://www.noridianmedicare.com/dme/claims/endeavor.html.

HETS to Replace CWF Medicare Beneficiary Health Insurance Eligibility Queries

MLN Matters® Number: SE1249

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. By 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, will be 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, soon thereafter. 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

In the coming months, CMS plans to discontinue access to the CWF queries through the shared systems: MCS PPTN, VMS VPIQ and FISS DDE. 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?

HETS returns all of the information provided by the CWF eligibility queries that is needed to process Medicare claims with the exception of psychiatric information. 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.

HETS returns some information in a format that differs from the CWF format. In addition, there is a change underway to allow HETS to return Hospice information in the same format as CWF. 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.

HMO Listing Published and Available on CMS Website

CMS publishes a Health Maintenance Organization (HMO) plan directory (Microsoft Excel format) that includes the HMO company name, contract number (i.e., H1234), address and phone number. This information is accessible from the CMS website, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Plan-Directory.html. This resource should be accessed when a Medicare beneficiary eligibility inquiry indicates the patient has elected an HMO plan to assist a supplier in locating/billing the correct insurance company for the items they are providing.

IVR Enhanced to Offer Expanded Eligibility Information

Effective November 9, 2012, the eligibility portion of the NAS Interactive Voice Response (IVR) System, 1-877-320-0390, has been expanded to offer additional information. The additional information includes information pertaining to Skilled Nursing Facility and inpatient hospitalization, date of death, Medicare Secondary Payer (MSP), and crossover-claim information. Additional information regarding these enhancements is provided within this article.

To conduct a Medicare beneficiary eligibility inquiry using the IVR, the following steps are necessary:

1. Call the IVR, 1-877-320-0390
2. Provide the state in which the beneficiary resides
3. From the main menu select Option 2 on the touch tone keypad or speak, "Eligibility"

Based on the type of eligibility inquiry requested, the following information may be requested:

4. National Provider Identifier (NPI)
5. Provider Transaction Access Number (PTAN)
6. Last five digits of the Tax Identification Number (TIN)
7. Beneficiary's first and last name as it appears on the Medicare card
8. Beneficiary's Medicare Number
9. Beneficiary's date of birth
10. Date of service
11. Diagnosis Code (first three digits of ICD-9-CM)

Information Available
By default, eligibility will provide:

- Part A and Part B effective and termination dates
- Part B deductible – if it has been met for the current year and the prior year
- If applicable, the IVR will provide the new Medicare number assigned to the beneficiary
- Health Maintenance Organization information, including the HMO name and phone number if applicable
- Home health information (based on date of service given)
- Hospice information (based on date of service given)
- If applicable, the IVR will say if Medicare is secondary to another insurance

The new eligibility features offers "Eligibility Details." When the eligibility details are offered, speak "Hospital SNF Episodes", "Crossover", "Date of Death", or "MSP". As an alternative to speaking one of these options, a touch tone alternative is available.

Touch-tone Option	Vocal Option
1	Hospital SNF Episodes
2	Crossover
3	Date of Death
4	MSP

The IVR provides the following information to the caller:

- Hospital SNF Episodes – the admission and/or discharge date of the SNF or inpatient hospitalization as well as the facilities' NPI to assist the supplier in coordination of care using the NPESS website, https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. If there are multiple records, the IVR will return the most current record before offering the "next record" and continue through reverse chronological order of available records.

- Crossover information for claims that will be sent to an insurance company after Medicare has processed claims based on those insurance company's predefined criteria. The name and address of the primary insurance company is provided with this new eligibility feature.
- Date of Death information can be provided when a caller prompts the IVR for that date of death by selecting this option from the eligibility details navigation menu option.
- MSP information including diagnosis-specific coverage and notification if the beneficiary has multiple primary insurance company policies according to national records. This selection requires the entry of the first three digits of the beneficiary's diagnosis code (ICD-9-CM). The results will either state Medicare is primary and there are no other records on file or will provide the name and address of the primary insurance company.
    - For example, a beneficiary was in a work-related accident and injured their back; diagnosis 724.5. The beneficiary had an unrelated need a few months later for a Positive Airway Pressure device based on the diagnosis 327.23. In this situation, the work-related insurance information will not be provided because the diagnosis for the wheelchair eligibility entry differs from the work-related injury diagnosis. The IVR is programmed to compare and return only applicable MSP information.

Suppliers are encouraged to share this added functionality with staff members who use the NAS IVR to conduct eligibility.

IVR Navigation Menu Changes: Impacts Financial, Pricing, and PMD Prior Authorization Options

The NAS DME Jurisdiction D Interactive Voice Response (IVR) System, 877-320-0390, had a navigation menu change on November 9, 2012. This change was made to better align the pricing feature with the financial menu option while also accommodating the new Power Mobility Device Prior Authorization status inquiry feature. The main menu options are provided within this article to assist our suppliers with the change.

Touch-tone Option	Vocal Option	High Level of Features
1	Claim Status	Claim Processing Results and Overlapping Claims
2	Eligibility	Entitlement, Deductible, Hospital and SNF episodes, Medicare Secondary Payer, Crossover, and Date of Death
3	Power Mobility Device Prior Authorization	Status and affirmative or non-affirmative decision with Unique Tracking Number
4	Same or Similar HCPCS Lookup	Specific DMEPOS Medicare has on file for the beneficiary
5	Duplicate Remittance Advice	Initiate the mailing of a duplicate remittance advice to the registered address on file
6	Provider Enrollment	Indication if the Ordering/Referring physician is enrolled in PECOS
7	Financial	Check Status, Payment Floor, Overpayments, and Pricing
8	Appeals	Appeal Status and decision outcome
9	Questions	General information
0	Customer Service Representatives	Complex questions that cannot e answered using the IVR

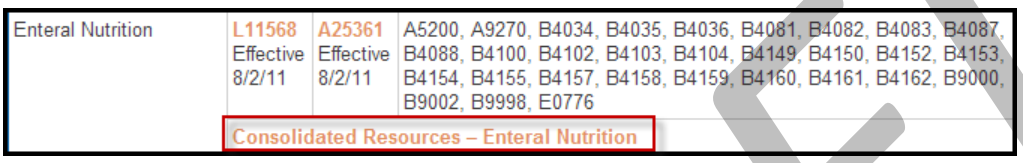
The IVR at-a-Glance and User Guide will have the necessary changes incorporated shortly. Suppliers are encouraged to share this article with those who use the NAS IVR.

Policy-specific Resources Accessible on Consolidated Webpage

To assist suppliers with their experience using the NAS website, we have developed Consolidated Resource webpages for the following policies: enteral nutrition, glucose monitors, oxygen, positive airway pressure devices, power mobility devices, refractive lenses, therapeutic shoes for persons with diabetes, wheelchair options/accessories, and wheelchair seating. The consolidated resource webpages provide links to the Local Coverage Determination and related Policy Article, documentation, education, reviews/audit information, and publications all on one page for specific policies.

Suppliers may access these pages two ways:

1. Current Local Coverage Determination (LCD) page: https://www.noridianmedicare.com/dme/coverage/lcd.html
   a. Control + F to find the policy or scroll down the page
   b. Consolidated Resources is located below the LCD and Policy Article identification number.

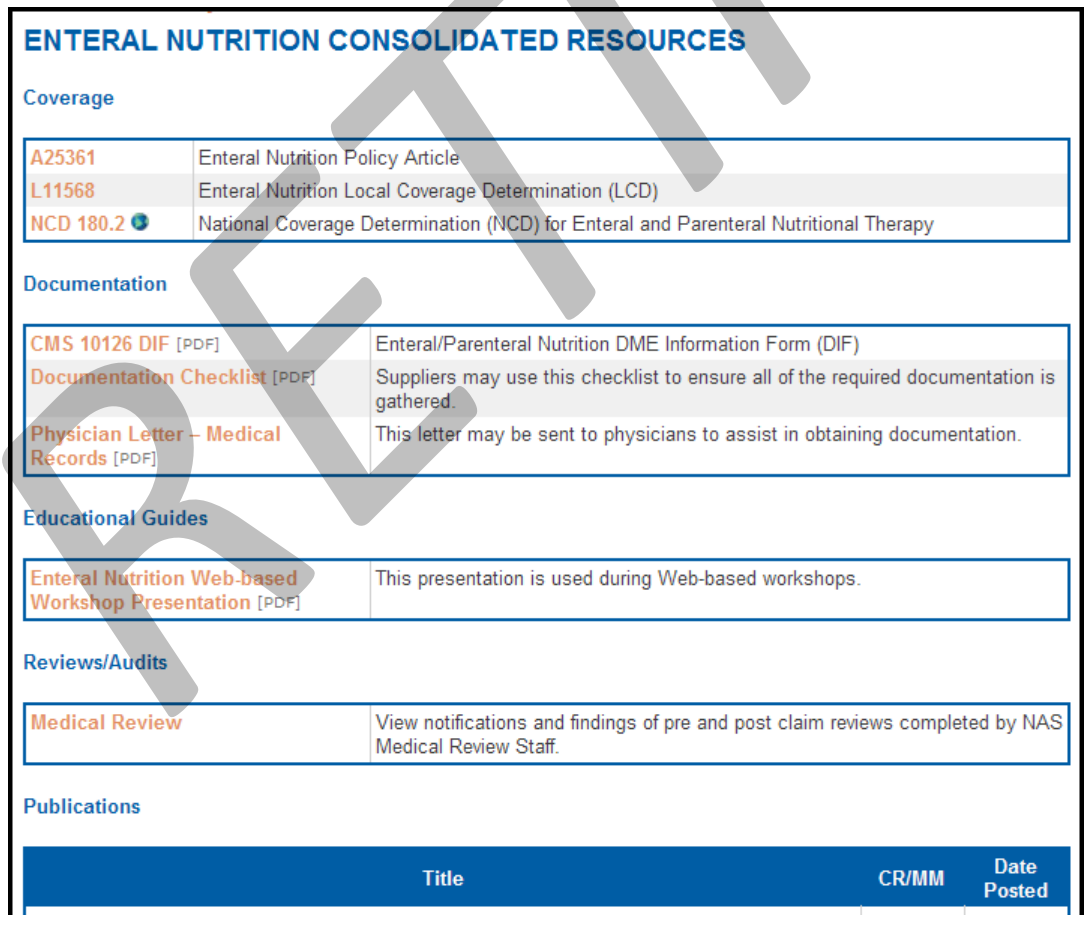


Enteral Nutrition	L11568 Effective 8/2/11	A25361 Effective 8/2/11	A5200, A9270, B4034, B4035, B4036, B4081, B4082, B4083, B4087, B4088, B4100, B4102, B4103, B4104, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9000, B9002, B9998, E0776
	Consolidated Resources – Enteral Nutrition		

2. Training and Events page: https://www.noridianmedicare.com/dme/train/
   a. Control + F to find the policy or scroll down the page
   b. Consolidated Resources is located under the Workshop Material/Q&A/Tutorials column

Enteral Nutrition	• Presentation – June 2012 [PDF 476 KB] • Consolidated Resources

The following is an example of the Enteral Nutrition Consolidated Resources page:



ENTERAL NUTRITION CONSOLIDATED RESOURCES

Coverage

A25361	Enteral Nutrition Policy Article
L11568	Enteral Nutrition Local Coverage Determination (LCD)
NCD 180.2	National Coverage Determination (NCD) for Enteral and Parenteral Nutritional Therapy

Documentation

CMS 10126 DIF [PDF]	Enteral/Parenteral Nutrition DME Information Form (DIF)
Documentation Checklist [PDF]	Suppliers may use this checklist to ensure all of the required documentation is gathered.
Physician Letter – Medical Records [PDF]	This letter may be sent to physicians to assist in obtaining documentation.

Educational Guides

Enteral Nutrition Web-based Workshop Presentation [PDF]	This presentation is used during Web-based workshops.

Reviews/Audits

Medical Review	View notifications and findings of pre and post claim reviews completed by NAS Medical Review Staff.

Publications

Title	CR/MM	Date Posted

NAS looks forward to supplier feedback regarding this enhancement. Suppliers are encouraged to complete the ForeSee Results website satisfaction survey, if prompted, from our website. Additional Consolidated Resource pages will be added for several other policies in the near future.

Reopening and Redetermination Submission & Status Inquiry Available Through Endeavor

Suppliers are encouraged to use the free Endeavor portal to submit written reopening and redeterminations and supporting documentation, check the status of appeals, and view finalized decision letters. Using Endeavor will help prevent recent fax issues.

Reopening and Redetermination Submission

- Submit the request and supporting documentation via Endeavor.

Check Status of Submitted Reopening or Redetermination

- **Important**: When inquiring on status, enter the patient's Medicare number or confirmation number to narrow the number of results and avoid timing out.
- Pending (Reopening/redetermination has been received by NAS)
- Request for Documentation (A documentation request has been sent to your office. Return the additional documentation to NAS within 14 days from the date of the letter.)
- Complete (Reopening/redetermination is finalized)

Registration for Existing Endeavor Users

1. Log into Endeavor.
2. Click on "Add Provider" in the left column.
3. Complete the form.
   - Ensure the correct Medicare Program is selected.
   - Enter the National Provider Identifier (NPI).
   - Check the Redetermination box.
   - Click the "Add to Provider List" button.
4. Repeat steps above for each requested NPI.
5. Click on the "Complete Registration" button.

Notes:

- **NPIs will *not* be automatically added to accounts. Each NPI must be processed by NAS Endeavor staff.**
- Users will receive an approval/denial fax after processing.

Registration for Providers New to Endeavor

1. Go to www.noridianmedicare.com/dme.
2. Click Log In/Register in the right column.
3. Click on "New User Registration".
4. Read the Registration Requirements and accept the terms of the agreements.
5. Complete the Organization page providing first and last name, organization name, and user type.
6. Complete the Contact page providing address, phone number, fax number, email address and System Security Official information.
7. Complete the Provider page entering the Medicare Program, NPI and selecting the transactions (eligibility, claim status, remittance advice, redeterminations).

SELF-SERVICE CONT'D

Notes:

- Once submitted, NAS Endeavor staff will process the registration.
- Each person using Endeavor must register for their own User ID.

User Manual
Instructions on using Endeavor and this new functionality are available in the User Manual [PDF] located on the Claims page.

Benefits of Reopening and Redetermination Submission and Status

- The benefits of submitting redeterminations through Endeavor include:
- No hidden fees, Endeavor is a free provider portal
- No software to download or install, Endeavor uses an Internet connection
- Registration is fast and easy
- User friendly
- Cost savings – no mailing of redeterminations (save on faxing, paper, postage and which could result in quicker payment turnaround)
- Timeliness – redeterminations are received instantly when submitted electronically via Endeavor
- Confirmation – receive confirmation of redetermination receipt
- Go Green – records can be submitted electronically

Hours of Availability

- Eligibility:
  - 24 hours/day, 7 days/week
- Claim Status, Same or Similar, Claim-Specific Remittance Advices, Overpayments and Reopening and Redetermination Submission/Status:
  - Monday – Friday: 6 a.m. – 8 p.m. CT
  - Saturday: 7 a.m. – 3 p.m. CT

Questions
Questions regarding DME Endeavor must be directed to dmeendeavor@noridian.com.

SURGICAL DRESSINGS

Collagen Surgical Dressings – Coding Verification Review Requirement

Recently the Center for Medicare & Medicaid Services (CMS) made a coding and benefit category determination on certain collagen surgical dressings. Based on this determination, all collagen surgical dressings are being compared to the characteristics of the *predicate product.* A predicate product is the product(s) used in the establishment of the original code set and is the product to which all other products are compared. In the case of collagen dressings, the predicate product contained 90% collagen. For a product to be assigned to a collagen dressing category, the dressing must contain at a minimum, 90% collagen, unless otherwise specified within the HCPCS code (e.g. per gram of collagen).

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 the product recently reviewed by CMS. 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.

SURGICAL DRESSINGS CONT'D

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 . 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/.

The Surgical Dressing Local Coverage Determination and Policy Article will be updated with this information at a later date.

TENS

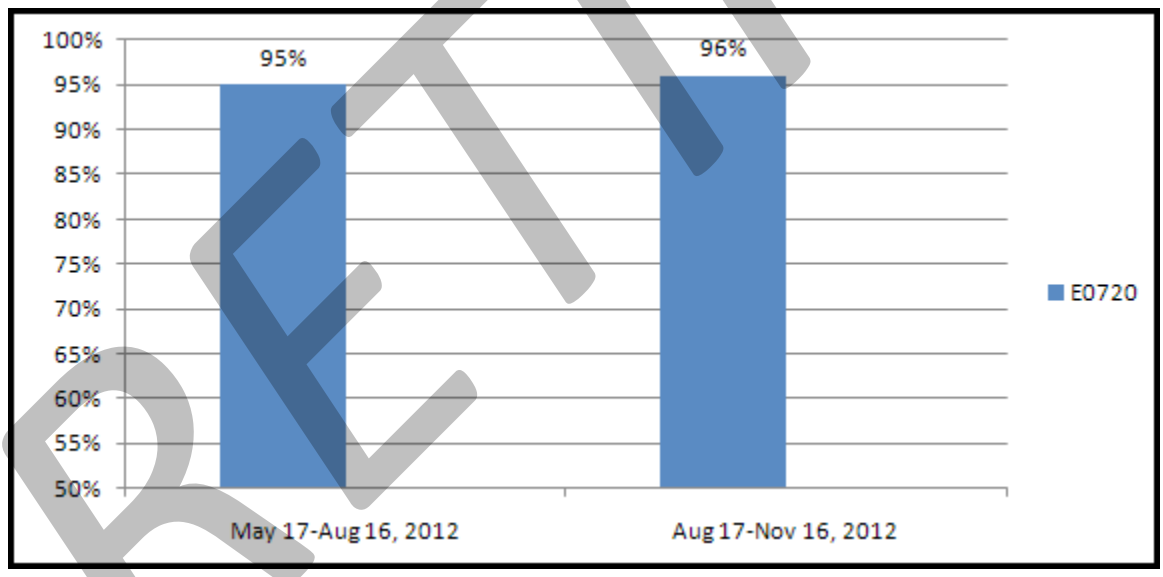
Second Quarter Results of Widespread Prepayment Review of Claims for Transcutaneous Electrical Nerve Stimulators 2-Lead (HCPCS E0720)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0720. The second quarter edit effectiveness results from August 2012 through November 2012 are as follows:

- The E0720 review involved 61 claims of which 58 were denied. This resulted in an overall error rate of 96%.

Historical Data of the Error Rate for E0720 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 20% of E0720 claims received a denial as medical documentation was either not submitted or did not support the TENS usage and frequency.

Per LCD L11495, the physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results. **Please note the TENS LCD has been updated. Refer to LCD L11495 for current guidelines**.

- 16% of E0720 claims received a denial as medical documentation was either not submitted or did not document 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 what treatment modalities have been used. **Please note the TENS LCD has been updated. Refer to LCD L11495 for current guidelines**.

14% of E0720 claims received a denial as medical documentation was either not submitted or did not document trial criteria.

Per LCD L11495, when used for the treatment of chronic, intractable pain, the TENS unit must be used by the patient 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 patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results. **Please note the TENS LCD has been updated. Refer to LCD L11495 for current guidelines**.

- 10% of E0720 claims received a denial as documentation was not submitted.

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

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 Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

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

TENS for Chronic Low Back Pain

MLN Matters® Number: MM7836 Revised
Related Change Request (CR) #: CR 7836
Related CR Release Date: November 30, 2012
Related CR Transmittal #: R2605CP and R149NCD
Effective Date: June 8, 2012
Implementation Date: January 7, 2013

Note: This article was revised on December 4, 2012, to reflect a revised CR7836, issued on November 30, 2012. In this article, the CR transmittal numbers, release date, and the Web address for accessing CR7836 have been revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare contractors (carriers, Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Transcutaneous Electrical Nerve Stimulation (TENS) services provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 7836 which informs providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is revising the coverage for TENS for Chronic Low Back Pain (CLBP) effective for claims with dates of service on or after June 8, 2012. See the Key Points section of this article for specific coverage rules and review the lists of ICD- 9 and ICD-10 codes attached to the official instruction CR7836.

TENS CONT'D

Background
In 2010, the Therapeutic and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published a report finding TENS ineffective for CLBP. CMS internally initiated a new national coverage determination (NCD) after the AAN published report and reviewed all the available evidence on the use of TENS for the treatment of CLBP.

Medicare has four NCDs pertaining to various uses of TENS that were developed before the CMS adoption of an evidence based and publicly transparent paradigm for coverage decisions. Those four NCDs are:

- Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2);
- Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1);
- Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13); and
- Transcutaneous Electrical Nerve Stimulators (TENS) (280.13). Please note, section 280.13 has been removed from the NCD manual and incorporated into NCD 160.27

The evidentiary basis is unclear for historic coverage. TENS has been historically thought to relieve chronic pain but the current evidence base refutes this assertion when applied to TENS for CLBP. Since TENS falls within the durable medical equipment (DME) benefit, Medicare coverage results in purchase after a brief initial rental period, even if the patient soon develops a subsequent tolerance to the TENS effect.

Key Points
Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will only allow coverage of TENS for CLBP defined for this decision as pain for 3 months or longer and not a manifestation of a clearly defined and generally recognizable primary disease entity, when the patient is enrolled in an approved clinical study under coverage with evidence development (CED).

Note: CED coverage expires three years from the effective date of this CR, June 8, 2015.

Examples of clearly defined and recognizable primary disease entities: neurodegenerative (e.g. multiple sclerosis) disease, malignancy, or well-defined rheumatic disorders (except osteoarthritis).

Medicare contractors will accept and process line items that include an appropriate TENS HCPCS code, at least one ICD-9 diagnosis code for CLBP (see list of ICD-9 codes attached to CR7836), and **all** of the following:

- Date of service on or after June 8, 2012;
- Modifiers KX and Q0;
- ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only);
- Condition code 30 - (for institutional claims only)
- An acceptable ICD-9 code; and
- An acceptable ICD-10 code upon implementation (see list of ICD-10 codes attached to CR7836).

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2605CP of CR7836 at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group Code CO;
- Claim Adjustment Reason Code B5 (Coverage/program guidelines were not met or were exceeded.); and
- Remittance Advice Remark Code N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Medicare will pay for allowed TENS for CLBP based on the DME fee schedule.

All of the following conditions must be met for coverage of TENS for CLBP:

CLBP is defined as:

- An episode of low back pain that has persisted for three months or longer; and
- Is not the manifestation of a clearly defined and generally recognizable primary disease entity.

For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom. Certain systemic diseases, e.g. rheumatoid arthritis, multiple sclerosis etc, manifest many debilitating symptoms of which low back pain is not the primary focus. CMS believes that the appropriate management of these types of diseases is guided by a systematic strategy aimed at the underlying causes. While TENS may infrequently be used adjunctively in managing the symptoms of these diseases, it is clearly not the primary therapeutic approach.

The patient is enrolled in an approved clinical study that addresses one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.

1. Does the use of TENS provide a clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
2. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
3. Does the use of TENS provide a clinically meaningful reduction in other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R149NCD of CR7836. That transmittal is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf on the CMS website.

Additional Information
The official instruction, CR 7836, issued to your Medicare Carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the NCD Manual and it is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf on the CMS website. The other transmittal updates the "Medicare Claims Processing Manual" and it is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf on the CMS website.

TENS Sold Over-the-Counter – Coding Guidelines

The Food and Drug Administration (FDA) has several product classifications for Transcutaneous Electrical Nerve Stimulators (TENS) devices, one of which is designated for TENS devices that may be sold over-the-counter (OTC). OTC TENS are identified with FDA product code NUH. OTC TENS are not considered durable medical equipment (DME). OTC TENS must be coded using HCPCS code:

A9270 - Non-covered item or service

Contact the Pricing, Data Analysis and Coding (PDAC) contractor for more information about the correct coding for TENS.

Refer to the Supplier Manual, Transcutaneous Electrical Nerve Stimulation Devices LCD and Related Policy Article for additional information.

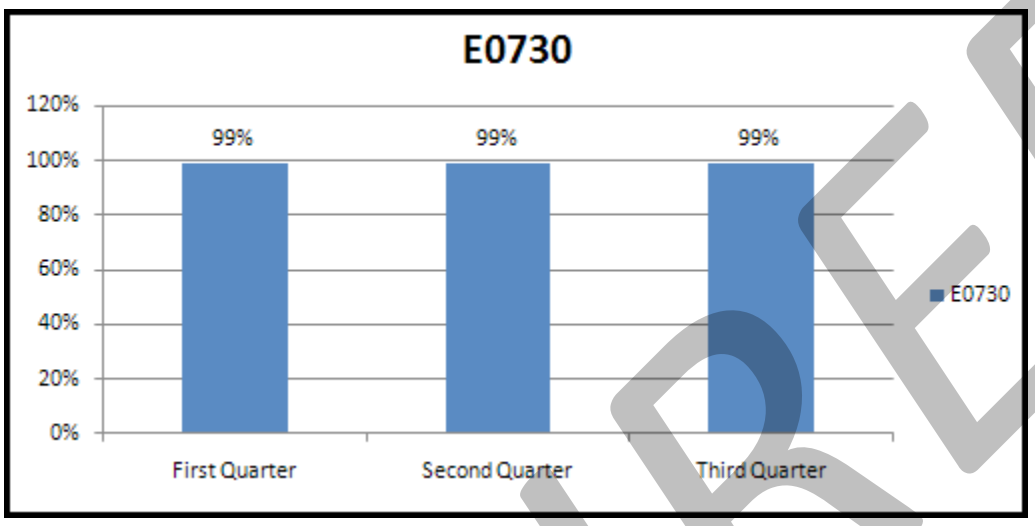
Third Quarter Results of Widespread Prepayment Review of Claims for TENS Device, Four or More Leads (HCPCS E0730)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS the code E0730. The third quarter edit effectiveness results from October 2012 through January 2013 are as follows:

- The E0730 review involved 136 claims of which 134 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

- 16% of E0730 claims received a denial as there is no documentation or 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.

- 13% of E0730 claims received a denial as there was no documentation or 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.

- 11% of E0730 claims received a denial as no documentation was received.

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

Going Forward

Based on the 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 Transcutaneous Electrical Nerve Stimulators Local Coverage Determination (LCD) L11495 and Policy Article A37074 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/.

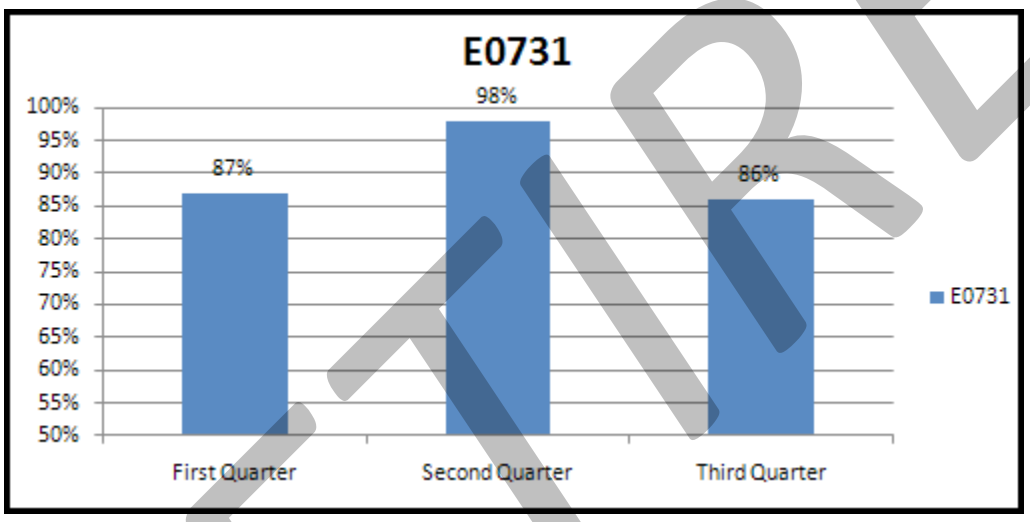
Information about probe/error validation reviews may be found in CMS Publication 100-8, *Program Integrity Manual* (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

Third 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 third quarter edit effectiveness results from October 2012 through January 2013 are as follows:

- The E0731 review involved 174 claims of which 146 were denied. This resulted in an overall error rate of 86%.

Historical Data of the Error Rate for the E0731 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 33% of E0731 claims received a denial as no documentation was received.

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

- 13% of E0731 claims received a denial as the documentation does not support coverage of the garment purchase.

TENS CONT'D

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.

- 6% of E0731 claims received a denial as there was no brand name or model number provided.

Per LCD L11495**,** Each claim for code E0731 must be accompanied by the brand, name and model number of the conductive garment.

- 6% of E0731 claims received a denial as there is no documentation or the documentation provided does not support why the 2 leads are insufficient to meet the patient's needs.

Per LCD L11495**,** A 4-lead TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the beneficiary's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the beneficiary's needs.

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 **Transcutaneous Electrical Nerve Stimulators** Local Coverage Determination (LCD) L11495 and Policy Article A37074

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

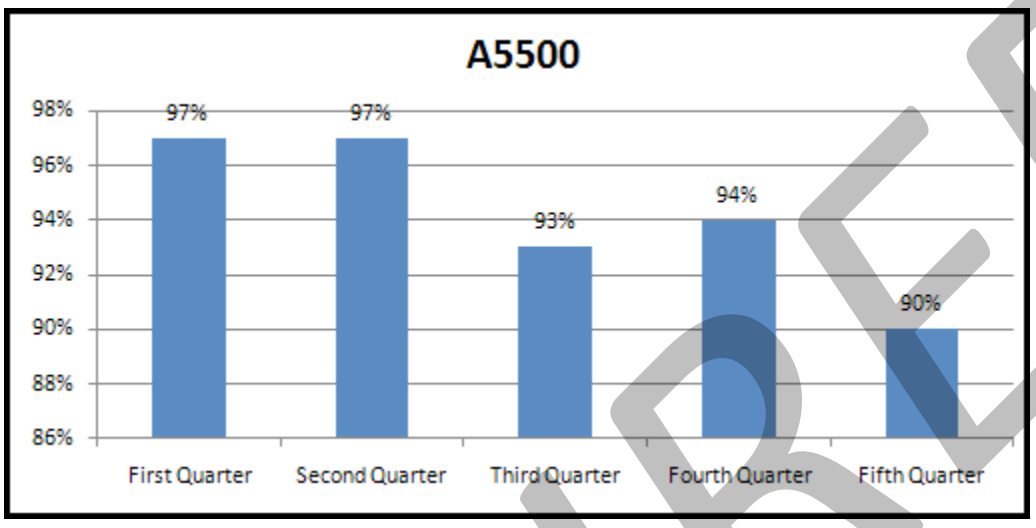
Fifth Quarter Results of Widespread Prepayment Review of Claims for Therapeutic Shoes (HCPCS A5500)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A5500. The fifth quarter edit effectiveness results from September 2012 through November 2012 are as follows:

The A5500 review involved 2178 claims of which 1950 were denied. This resulted in an overall error rate of 90%.

Historical Data of the Error Rate for A5500 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 26% of A5500 claims received a denial as Criterion 2 was not met per Policy Article (PA) A37076.

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

a. Previous amputation of the other foot, or part of either foot, or

b. History of previous foot ulceration of either foot, or

c. History of pre-ulcerative calluses of either foot, or

d. Peripheral neuropathy with evidence of callus formation of either foot, or

e. Foot deformity of either foot, or

f. Poor circulation in either foot;

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

g. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or

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

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

- 20% of A5500 claims received a denial as Criterion 3 was not met per PA A37076.

There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

a. Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and

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

Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

- 8% of A5500 claims received a denial as there was no documentation from the supplier to support an in-person visit at the time of delivery per Local Coverage Determination (LCD) L157 and PA A37076

There must be documentation from the supplier to support an in-person visit at the time of delivery. The supplier must conduct and document an in-person visit with the patient. The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

- 7% of A5500 claims received a denial as there was no documentation from the supplier to support an in-person visit prior to selection of the item billed per Local Coverage Determination (LCD) L157 and PA A37076.

There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

3. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.

4. For all shoes, taking measurements of the patient's feet.

5. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's fee that will be used in creating positive models of the feet.

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 Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076.

Suppliers can also review specific policy resources for Therapeutic Shoes for Persons with Diabetes on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/therapeutic_shoes_for_persons_with_diabetes.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian 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#tools.

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

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Fargo, ND 58103-2146

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