DME Happenings

Jurisdiction D
Issue No. 40
August 2013

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

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Noridian Healthcare Solutions, LLC

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Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

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

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

CONTACT US

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

FYI

2013 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Event	Date	Closure Timeframe
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	November 15	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	November 22	9:30 a.m. – 12 p.m. CT
Thanksgiving	November 28 and 29	Entire Day Closed 8 a.m. – 6 p.m. CT
Off-the-Phone Training	December 13	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 20	9:30 a.m. – 12 p.m. CT
Christmas	December 24	12 – 6 p.m. CT
Christmas	December 25	Entire Day Closed 8 a.m. – 6 p.m. CT

Telephone Reopenings

The Noridian Telephone Reopening Team will be closed for the entire day (8 a.m. through 4:30 p.m. CT) in recognition of holidays. Additionally, the Telephone Reopening team will be closed the first Friday of each month between 8 a.m. and 10 a.m. CT and the second through fourth Fridays of each month from 9:30 – 11:30 a.m. CT to receive training. The holiday and training closures are provided below.

Event	Date	Closure Timeframe
Off-the-Phone Training	August 23	9:30 – 11:30 a.m. CT
Labor Day	September 2	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	September 6	8 – 10 a.m. CT
Off-the-Phone Training	September 13	9:30 – 11:30 a.m. CT
Off-the-Phone Training	September 20	9:30 – 11:30 a.m. CT
Off-the-Phone Training	September 27	9:30 – 11:30 a.m. CT
Off-the-Phone Training	October 4	8 – 10 a.m. CT
Off-the-Phone Training	October 11	9:30 – 11:30 a.m. CT
Off-the-Phone Training	October 18	9:30 – 11:30 a.m. CT
Off-the-Phone Training	October 25	9:30 – 11:30 a.m. CT
Off-the-Phone Training	November 1	8 – 10 a.m. CT
Off-the-Phone Training	November 15	9:30 – 11:30 a.m. CT
Off-the-Phone Training	November 22	9:30 – 11:30 a.m. CT
Thanksgiving	November 28 and 29	Entire Day Closed 8 a.m. – 4:30 p.m. CT
Off-the-Phone Training	December 6	8 – 10 a.m. CT
Off-the-Phone Training	December 13	9:30 – 11:30 a.m. CT
Off-the-Phone Training	December 20	9:30 – 11:30 a.m. CT
Christmas	December 24	12 – 4:30 p.m. CT
Christmas	December 25	Entire Day Closed 8 a.m. – 4:30 p.m. CT

Additional Time to Establish Protocols for Newly Required Face-to-Face Encounters for DME

Due to concerns that some providers and suppliers may need additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for certain items of Durable Medical Equipment (DME), CMS will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on October 1, 2013.

Section 6407 of the ACA established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant, or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

Although many DME suppliers and physicians are aware of and are able to comply with this policy, CMS is concerned that some may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the next several months, suppliers and physicians who order certain DME items will continue to collaborate and establish internal processes to ensure compliance with the face-to-face requirement. CMS expects durable medical equipment suppliers to have fully established such internal processes and have appropriate documentation of required encounters by October 1, 2013.

CMS will continue to address industry questions concerning the new requirements and will update information on our Medical Review and Education website. CMS and its contractors will also use other communication channels to ensure that the provider community is properly informed of this announcement.

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

Quarterly Provider Updates

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

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

Let Your Voice be Heard!

Register to participate in the Medicare Administrative Contractor (MAC) Satisfaction Indicator (MSI). The MSI is a tool that measures your satisfaction with the Medicare claims administration contractor(s) that serve you. The contractors and Centers for Medicare and Medicaid Services (CMS) will use the results of the MSI to improve the level of service offered to all Medicare Fee-For-Service (FFS) providers.

Registration opened on July 8, 2013 and should take less than 1 minute to complete. Those participants who are selected in the random sample will have an opportunity to express their satisfaction with their MAC to CMS.

If you are a Medicare FFS provider or work on behalf of a Medicare FFS provider (such as a billing agency) and are interested in participating, take a moment to register your contact information by completing the application at https://adobeformscentral.com/?f=eMRKPqaWpqMxNOmTQpSKDA

For more details about the MSI, visit http://www.cms.gov/Medicare/Medicare-Contracting/MSI/.

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."

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

Sources for "Jurisdiction D Happenings" Articles

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

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

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
Appendix	Acronyms	Added Current Procedural Terminology (CPT)	08/02/13
1	Noridian's Role as a DME MAC	Changed from 30,000 suppliers to 19,000	07/10/13
1	Noridian's Role as a DME MAC	Added information about JE Contract	07/10/13
3	Medicare HMO Beneficiaries	Removed paragraph 3	07/10/13
4	Transmission of CMN	Updated link	07/10/13
9	Advance Determination of Medicare Coverage	Added info on K0009 end date and new custom chairs	07/10/13
11	Coordination of Benefits	Updated link	07/10/13
15	Recovery Auditor Overpayments	Updated the link	07/10/13
Appendix	Resources	Updated Telephone Reopenings Hours	07/10/13
13	Reopenings	Updated hours of availability	05/14/13

Reconsideration and Administrative Law Judge Time Limit Calculators Now Available

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

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

Entry Tips

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

Calendar Tool Usage'

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

Redaction of HICNs in Medicare Redetermination Notices

MLN Matters® Number: MM8268
Related Change Request (CR) #: CR 8268
Related CR Release Date: July 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1258OTN
Implementation Date: January 6, 2014

Provider Types Affected

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

What You Need to Know

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

Background

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

Additional Information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1258OTN.pdf on the CMS website.

Telephone Reopenings Available 8 a.m. – 4:30 p.m. CT

To better serve our customers, DME Telephone Reopenings has extended its hours! The Telephone Reopening line is now available Monday through Friday from 8 a.m. - 4:30 p.m. CT at 888-826-5708. The Telephone Reopening line will be closed on the following occasions for training purposes:

- 1st Friday of each month from 8 – 10 a.m. CT
- 2nd , 3rd and 4th Friday of each month from 9:30 – 11:30 a.m. CT

When calling Telephone Reopenings, please have the following information available:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of Tax ID Number (TIN)
- Company name
- Beneficiary's Medicare number, name and date of birth

Telephone Reopenings: What Can and Cannot be Requested

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

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

How do I request a telephone reopening?	Requesting a telephone reopening is simple, call 1-888-826-5708.
What are the hours of operation for the telephone reopenings?	Monday through Friday 8 a.m. until 4:30 p.m. CT Additional closing information can be found at https://www.noridianmedicare.com/dme/contact/holiday.html.

What do I need to have before I can initiate a telephone reopening?	Before a reopening can be completed, all of the following information must be readily available by the caller and will be verified by the telephone reopening representative. • Supplier Number (Provider Transaction Access Number (PTAN)) • National Provider Identifier (NPI) • The last five digits of the Tax ID Number (TIN) • Supplier name • Beneficiary Health Insurance Claim Number (HICN) • Beneficiary last name and first initial • Beneficiary date of birth • Date of service • Claim Control Number (CCN) of claim • Billed amount • Healthcare Common Procedure Coding System (HCPCS) code in question • Corrective action to be taken **NOTE:** If at any time the information does not match the information housed in the claims processing Medicare System, the telephone reopening cannot be completed.

What may I request as a telephone reopening?	The following is a list of clerical errors and omissions that may be completed as a telephone reopening. This list is not all-inclusive:
	• Diagnosis changes/additions
	• Date of service changes
	• HCPCS code changes
	• Certificate of Medical Necessity (CMN)/DME Information Form (DIF) updates (*with the exception of parenteral and enteral nutrition and oxygen Break In Service (BIS) which must be sent in as a written reopening or redetermination*)
	• Certain modifier changes/additions (not all inclusive list):
	  • KH – DMEPOS item, initial claim, purchase or first month
	  • KI – DMEPOS item, second or third month rental
	  • KJ – DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
	  • RR – Rental
	• Surgical dressing (when number of services are within the policy – if the request is to allow over the policy amount, these must go to written redeterminations)
	• Wheelchairs – HCPCS K0004 and lower
	NOTE: If any of the above changes, upon research, are determined to be too complex, the requester will be notified that the request needs to be sent in writing, with the appropriate documentation, as a redetermination.

What is not accepted as a telephone reopening?	The following will not be accepted as a telephone reopening. These items must be submitted along with all supporting documentation as a redetermination. • Any item billed over the allowance listed in the medical policy – documentation is required to support amount billed • Parenteral and enteral DIF issues • Oxygen BIS • Wheelchairs/power mobility devices – HCPCS K0005 and higher • Recoupment/reduction of payment – complete Refunds to Medicare form • Medicare Secondary Payer (MSP) – send inquiry to MSP department • Timely denials – claims submitted within appropriate time frame • Late files – reopening and/or redetermination requests submitted within the appropriate time frame • Requests that require documentation • Advance Beneficiary Notice of Noncoverage (ABN) issues • A1–A9 modifiers • GA modifier • GY modifier • GZ modifier • KX modifier • HCPCS codes J1559, J1561, J1562 • Liability issues • Repairs to equipment • Miscellaneous codes • Labor codes **NOTE:** Claims with remittance message MA130 can **never** be submitted as a reopening. Claims with message MA130 are considered unprocessable and do not have reopening or redetermination rights. The claim is missing information that is needed for processing the claim or the claim information is invalid. These claims must be resubmitted with a new corrected claim.
What do I do when I have a large amount of the same correction?	In the event that a supplier has more than 50 of the same correction, that is able to completed as a reopening, 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.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8320
Related Change Request (CR) #: CR 8320
Related CR Release Date: May 24, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2713CP
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (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) 8320 which requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

All code changes approved during the June 2013 Committee meeting will be posted on or about July 1, 2013, at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes on the Internet. Make sure that your billing staffs are aware of these changes.

Background

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

The national Code Maintenance Committee meets three times each year (February, June, and October)in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on the date of implementation of CR8320 (October 7, 2013), your Medicare contractor must:

1. Complete the entry of all applicable code text changes and new codes;
2. Terminate the use of deactivated codes;

Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.

Additional Information

The official instruction, CR8320 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2713CP.pdf on the CMS website.

Electronic Claim Narratives – Reminder of Line Level Submission

NAS has noticed that some suppliers are providing a description of the DMEPOS provided in the 2400 loop, SV101-7 segment, which is a description field, rather than the NTE segment. Doing so will result in the claim being denied as a return/reject. For Not Otherwise Classified (NOC) Codes, we recommend sending the description in both the SV101-7 and the NTE segments to avoid receiving unnecessary rejections from the CEDI Front-end system as well as in our system.

The narrative given in the NTE segment should include but is not limited to the description of the item being billed, the HCPCS code the item being billed is related to and the MSRP or SRP of the item, if available. Suppliers should keep in mind that there is a limited amount of characters for the narrative. This may result in portions of information being cut off if too many characters are provided.

Modifiers and descriptions have been provided as they may be billed with the HCPCS. Any HCPCS below, regardless of the use of a modifier, would require a narrative be submitted with the claim.

HCPCS	Modifiers	Short Description
A4335		Incontinence supply
A4421		Ostomy supply misc
A4649		Surgical supplies
A5507		Modification diabetic shoe
A6261		Wound filler gel/paste /oz
A6262		Wound filler dry form / gram
A6512		Compres burn garment, noc
A9999		DME supply or accessory, nos
B9998		Enteral supp not otherwise c
B9999		Parenteral supp not othrws c
E0147		Walker variable wheel resist
E0769	NU, RR, UE	Electric wound treatment dev
E1229	NU, RR, UE	Pediatric wheelchair NOS
E1239	NU, RR, UE	Ped power wheelchair NOS
E1399	KF, NU, RR, UE, MS	Durable medical equipment mi
E2599	NU, RR	SGD accessory noc
E2609		Custom fabricate w/c cushion
E2617		Custom fab w/c back cushion
J1599		Ivig non-lyophilized, NOS
J3490		Drugs unclassified injection
J7198		Anti-inhibitor
J7199		Hemophilia clot factor noc
J7599		Immunosuppressive drug noc
J7699	KO, KP, KQ	Inhalation solution for DME
J7799		Non-inhalation drug for DME
J8498		Antiemetic rectal/supp NOS
J8499		Oral prescrip drug non chemo
J8597		Antiemetic drug oral NOS
J8999		Oral prescription drug chemo
J9999		Chemotherapy drug

HCPCS	Modifiers	Short Description
K0009	MS, NU, RR, UE	Other manual wheelchair/base
K0014	MS, NU, RR, UE	Other power whlchr base
K0108	NU, RR, UE	W/c component-accessory NOS
K0462		Temporary replacement eqpmnt
K0739		Repair/svc DME non-oxygen eq
K0812	NU	Power operated vehicle NOC
K0898		Power wheelchair NOC
L0999		Add to spinal orthosis NOS
L1499		Spinal orthosis NOS
L2999		Lower extremity orthosis NOS
L3649		Orthopedic shoe modifica NOS
L3999		Upper limb orthosis NOS
L4205		Ortho dvc repair per 15 min
L4210		Orth dev repair/repl minor p
L5999		Lowr extremity prosthes NOS
L7499	AV	Upper extremity prosthes NOS
L7510		Prosthetic device repair rep
L8039		Breast prosthesis NOS
L8048		Unspec maxillofacial prosth
L8505		Artificial larynx, accessory
L8699		Prosthetic implant NOS
Q0181		Unspecified oral anti-emetic
V2199		Lens single vision not oth c
V2299		Lens bifocal speciality
V2399		Lens trifocal speciality
V2499		Variable asphericity lens
V2599		Contact lens/es other type
V2629		Prosthetic eye other type
V2799		Miscellaneous vision service

Modifier descriptions have been provided as a convenience. Suppliers are encouraged to view the Pricing, Data Analysis and Coding contractor's website, https://www.dmepdac.com/dmecsapp, for HCPCS and modifier research:

- AV: Item Furnished in Conjunction with a Prosthetic Device, Prosthetic or Orthotic
- KF: Item Designated by FDA as Class III Device
- KO: Single Drug Unit Dose Formulation
- KP: First Drug of a Multiple Drug Unit Dose Formulation
- KQ: Second or Subsequent Drug of a Multiple Drug Unit Dose Formulation
- MS: Six Month Maintenance and Servicing Fee for Reasonable and Necessary Parts and Labor Which are not Covered Under any Manufacturer or Supplier Warranty
- NU: New Equipment

RR: Rental (Use the 'RR' Modifier When DME is to be Rented)

UE: Used Durable Medical Equipment

Additional situations in which a narrative should be submitted with a claim are accessible from the Noridian website, https://www.noridianmedicare.com/dme/claims/cms1500_08-05_instructions.html#19.

KB and 99 Modifiers–More than Four Modifiers

If modifiers KB or 99 are used incorrectly, i.e., used with three or fewer modifiers, claims will be rejected as unprocessable and suppliers will need to resubmit.

When a supplier uses more than four modifiers, the KB or 99 must be added as the fourth modifier to the HCPCS code. On paper claims, the remainder of the modifiers must be listed in Item 19 with an indicator as to which line the modifiers apply. On electronic claims, the remainder should be entered in the NTE segment, the 2400 loop. It is only appropriate to use the modifier KB or 99 when there is a need to use more than four modifiers on the claim line.

KB Beneficiary requested upgrade for ABN, more than four modifiers identified on claim.

99 Modifier overflow

The KB modifier only applies to beneficiary upgraded claims for DMEPOS where the supplier obtained an Advance Beneficiary Notice of Noncoverage (ABN) and there are more than four modifiers on the claim line. The 99 modifier is used in any other situation when a claim line has more than four modifiers.

New Claim Adjustment Reason Code to Identify Reduction in Federal Spending Due to Sequestration

MLN Matters® Number: MM8378
Related Change Request (CR) #: CR 8378
Related CR Release Date: July 25, 2013
Effective Date: June 3, 2013
Related CR Transmittal #: R2739CP
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8378 which informs Medicare contractors about a new Claim Adjustment Reason Code (CARC) reported when payments are reduced due to Sequestration. Make sure that your billing staffs are aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013. As a result, Medicare Fee-For-Service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. The Centers for Medicare & Medicaid services (CMS) previously assigned CARC 223 (Adjustment code for mandated Federal, State or Local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253 - Sequestration - Reduction in Federal Spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR8378.

Additional Information

The official instruction, CR 8378 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf on the CMS website.

New HCPCS Codes for Customized Durable Medical Equipment

MLN Matters® Number: MM8158 Revised
Related Change Request (CR) #: CR 8158
Related CR Release Date: May 21, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1239OTN
Implementation Date: July 1, 2013

Provider Action Needed

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

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

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

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

Background

Customized DME Items

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

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

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

BILLING

Payment for Customized DME Items

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

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

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

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

Additional Information

The official instruction, CR8158, issued to your Part A MAC or DME MAC regarding this change may be viewed http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1239OTN.pdf the CMS website.

COMPETITIVE BIDDING

Quarterly Update for DMEPOS Competitive Bidding Program - October 2013

MLN Matters® Number: MM8316
Related Change Request (CR) #: CR 8316
Related CR Release Date: May 24, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2712CP
Implementation Date: October 7, 2013

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8316 to provide the DMEPOS CBP October 2013 quarterly update. Change Request (CR) 8316 provides specific instructions for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

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

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

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

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

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

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

Additional Information

The official instruction, CR 8316, issued to your RHHI or DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2712CP.pdf on the CMS website.

To review the entire series of recent DMEPOS CBP Medicare Learning Network® (MLN) Fact Sheets go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/EducationalResources.html on the CMS website.

Round 2 DMEPOS Competitive Bidding Program: 120 Day Grace Period for Obtaining Written Orders

CMS will allow a grace period of 120 days (i.e., through October 31, 2013) for contract suppliers to obtain written orders for all competitive bidding items for beneficiaries that transition to them from a non-contract supplier beginning July 1, 2013.

This grace period is provided to give contract suppliers additional time to obtain the required written orders for the large volume of beneficiaries transitioning to them from non-contract suppliers at the start of the competitive bidding programs and does not apply to new patients who are obtaining the items for the first time.

In addition, beginning July 1, 2013, beneficiaries with Original Medicare who live in or travel to a Round 2 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding area who own a Continuous Positive Airway Pressure (CPAP) or respiratory assist device must obtain replacement of essential accessories (e.g., masks, tubing, etc.) necessary for the effective use of their devices from a contract supplier unless an exception applies. CMS will allow a grace period of 120 days (i.e., through October 31, 2013) for contract suppliers to obtain all medical necessity documentation to support medical necessity for replacement of accessories for use with beneficiary-owned CPAP or respiratory assist device.

Beginning November 1, 2013, suppliers will be expected to submit the required documentation upon request without exception. Absent such documentation, CMS contractors shall collect overpayments following established procedures. In cases where old suppliers do not provide the required documentation to the new supplier, or in other circumstances where documentation is not available, beneficiaries will need to visit their physician in order to obtain a new order to fulfill this requirement and other supporting documentation as appropriate.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

CERT Email Address Announced

Noridian Medicare DME is pleased to announce the creation of an email address for Comprehensive Error Rate Testing (CERT) related inquiries, jddmecert@noridian.com. The email address has been developed for suppliers in an effort to better assist with items such as clarification of CERT review requirements, obtaining the CERT reviewer comments on claims reviewed and general CERT education. Noridian will respond to all emails within two business days.

To better assist in responding to the email inquiries, please include the following information in the email:

1. CERT Claim Identification Number (CID) in the Subject line if applicable
2. Supplier name and address
3. Telephone number
4. Explanation of the issue, concern or question

NOTE: DO NOT include Protected Health Information (PHI) or Personal Identification Information (PII) in the email, either in the subject line OR in the body. PHI and PII includes, but is not limited to, the beneficiary's name, date of service, claim numbers or the beneficiary's Medicare Health Insurance Claim Number (HICN). PHI is NOT permitted to be transmitted via email.

CMS MLN Connects

May 16, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-16-Enews.pdf

National Provider Calls

- National Physician Payment Transparency Program (OPEN PAYMENTS) – What You Need To Know – Register Now
- Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series – Register Now
- Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier – Register Now
- Medicare Shared Savings Program Application Process – Register Now
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series
- Audio Recording and Written Transcript from April 24 "ESRD Low-Volume Payment Adjustment" Call Now Available

Announcements and Reminders

- Raise Awareness About Mental Health
- Reminder: DMEPOS Competitive Bidding Program: Grandfathering Requirements and Fact Sheet
- DMEPOS Competitive Bidding Program: Beneficiary and Provider Mailings
- HQRP Paperwork Reduction Act Package and Proposed Rule Available for Public Comment
- CMS to Release a Comparative Billing Report on Evaluation and Management Services – Target Release May 20
- Guidance for EPs: How to Participate in Both the Medicare EHR Incentive Program and PQRS in 2013 and Beyond

Claims, Pricer, and Code Updates

- Adjustment of Certain Institutional Provider Claims
- Temporary Billing Guidelines for Annual Wellness Visits and Initial Preventive Physical Examinations for Rural Health Clinics
- 2014 ICD-10-PCS Files Now Available
- FY 2014 ICD-9-CM Procedure Code Addendum Now Available
- Clarification on the Use of External Cause and Unspecified Codes in ICD-10-CM
- Dates of Service: Is It ICD-9 or ICD-10?

MLN Educational Products Update

- "Remittance Advice Information: An Overview" Fact Sheet – Released
- "Remittance Advice Resources" Fact Sheet – Released
- "ICD-10-CM/PCS Myths and Facts" Fact Sheet – Revised
- "Sole Community Hospital" Fact Sheet – Revised

May 23, 2013:

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-23-Enews.pdf

National Provider Calls

- Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series – Last Chance to Register
- Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier – Register Now
- PQRS and eRx Incentive Program Payment Adjustment – Registration Now Open
- Medicare Shared Savings Program Application Process – Register Now
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series – Save the Dates

Other Calls, Meetings, and Events

- Special Open Door Forum: Suggested Electronic Clinical Template for Lower Limb Prostheses
- New DMEPOS Educational Slideshow Presentation for non-Contract Suppliers
- Data.Medicare.Gov Get Started Webinar
- New Medscape Modules Now Available

Announcements and Reminders

- Eligible Medicare Beneficiaries May Receive Coverage for Bone Mass Measurements
- Application Deadlines for the Medicare Shared Savings Program January 1 Program Start Date
- Join a Community Portal Dedicated to Nursing Home Quality
- CMS is Accepting Suggestions for Potential PQRS and/or Measures Groups
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines
- Resource Available for CAH II Physicians Eligible to Participate in the Medicare EHR Incentive Program
- Several New and Updated FAQs on EHR Incentive Programs Now Available on CMS Website

Claims, Pricer, and Code Updates

- Assignment Violations on Claims for DMEPOS
- Change to Payment Liability for Therapy Cap Denials
- TOB 85X Medically Unlikely Edit Claims Adjudication Change
- CY 2013 Home Health PPS and FY 2013 Inpatient PPS PC Pricers – Updated

MLN Educational Products Update

- "Information on the National Physician Payment Transparency Program: OPEN PAYMENTS" MLN Matters® Article – Released
- "Medicare-Covered Services Furnished Outside the United States" Fact Sheet – Released
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet – Revised
- Submit Your Feedback on the MLN Learning Management System and Product Ordering System
- New MLN Provider Compliance Fast Fact
- New MLN Educational Web Guides Fast Fact

May 30, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-30-Enews.pdf

National Provider Calls

- Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier - Register Now
- PQRS and eRx Incentive Program Payment Adjustment - Register Now
- Medicare Shared Savings Program Application Process - Register Now
- Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology - Registration Opening Soon
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series - Save the Dates
- Video Slideshow Presentation from April 23 Call on the Medicare Shared Savings Program Application Process Now Available

Other Calls, Meetings, and Events

- PERM Cycle 2 Provider Education Webinar/Conference Calls

Announcements and Reminders

- Doctors and Hospitals' Use of Health IT More Than Doubles Since 2012
- Administration Announces $1 Billion Initiative to Launch Health Care Innovation Awards
- Application Deadlines for the Medicare Shared Savings Program January 1 Program Start Date
- Reporting Period to Submit eRx Data and Avoid Adjustment Ends June 30
- July 3rd is an Important EHR Deadline for Medicare Eligible Hospitals and CAHs
- The Role of Clearinghouses in the ICD-10 Transition

Claims, Pricer, and Code Updates

- Change in Electronic Remittance Advice (835) for Inpatient Claims
- Outpatient Therapy Services Functional Reporting Testing Period Ending June 30
- Inpatient Prospective Payment System PC Pricer Updated
- April Quarterly PPS Provider Data Updated

MLN Educational Products Update

- "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that Span the International Classification of Diseases, 10th Edition (ICD-10) Implementation Date" MLN Matters® Article - Released
- "Medicare Billing: 837P and Form CMS-1500" Fact Sheet - Revised

June 6, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-06-Enews.pdf.

National Provider Calls

- PQRS and eRx Incentive Program Payment Adjustment – Register Now
- Medicare Shared Savings Program Application Process – Register Now
- Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology – Registration Now Open
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier – Registration Now Open
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series – Save the Dates

Other Calls, Meetings, and Events

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

Announcements and Reminders

- Raising Awareness of Men's Health Issues and Prevention
- Secure Health Data Helping Patients, Doctors Improve Care and Health
- Deadline for Medicare Shared Savings Program: Form CMS-20037 Due June 10
- Submit Comments on CMS Proposed Rule Aligning EHR and the Hospital Inpatient Quality Reporting Program by June 25
- PV-PQRS Registration System Opening July 15
- ICD-10 Resources for FFS Providers Now Available
- CMS Announces Teaching Hospital Closures and Round 5 of Section 5506 of the Affordable Care Act
- Medicare EPs: How to Avoid Payment Adjustments for the EHR Incentive Program

Claims, Pricer, and Code Updates

- DMEPOS Competitive Bidding Round 2 Transitional Policy – CPAP Device Documentation Requirements

MLN Educational Products Update

- "Long-Term Care Hospital (LTCH) Quality Reporting Program Reminders" MLN Matters® Article – Released
- "Discharge Planning" Booklet – Released
- "Clinical Laboratory Improvement Amendments (CLIA)" Brochure – Revised
- "DMEPOS Quality Standards" Booklet – Revised
- "General Equivalence Mappings Frequently Asked Questions" Booklet – Revised
- "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet – Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet – Revised
- "The DMEPOS Competitive Bidding Program for Referral Agents" Fact Sheet – Revised
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet – Revised
- "Medicare Learning Network® Suite of Products and Resources for Compliance Officers" Educational Web Guide – Released
- "Medicare Learning Network® Suite of Products and Resources for Rural Health Providers" Educational Web Guide – Released
- "Medicare Learning Network® Suite of Products and Resources for Inpatient Hospitals" Educational Web Guide – Revised
- "Medicare Learning Network® Suite of Products and Resources for Educators and Students" Educational Web Guide – Revised

- "Medicare Learning Network® Suite of Products and Resources for Billers and Coders" Educational Web Guide – Revised

June 13, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-13Enews.pdf

National Provider Calls

- PQRS and eRx Incentive Program Payment Adjustment - Last Chance to Register
- Medicare Shared Savings Program Application Process - Register Now
- Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology - Register Now
- CMS National Partnership to Improve Dementia Care in Nursing Homes - Registration Now Open
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier - Register Now
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series - Save the Dates

Other Calls, Meetings, and Events

- PERM Cycle 2 Provider Education Webinar/Conference Calls
- New Medscape Module Available on EHRs in Practice: The Meaning of Meaningful Use

Announcements and Reminders

- Medicare Urges Seniors to Join the Fight Against Fraud
- CMS Launches QAPI Website for Nursing Homes
- HQRP Notification of Non-Compliance and Reconsideration Requests
- CMS to Release Comparative Billing Report on Hospice Services - Target Release June 21
- Reporting Period to Submit eRx Data and Avoid Adjustment Ends June 30
- PQRS Call for Measures Ends July 1
- July 3rd is an Important EHR Deadline for Medicare Eligible Hospitals and CAHs
- CMS has Released Updated Resources with Changes to Stage 1 Meaningful Use Objectives, Measures, and Exclusions

Claims, Pricer, and Code Updates

- Correction to "DMEPOS Competitive Bidding Round 2 Transitional Policy - CPAP Device Documentation Requirements" From June 6 e-News
- July 2013 Average Sales Price Files Now Available
- Inpatient Prospective Payment System PC Pricer Updated

MLN Educational Products Update

- June 2013 Version of the "Medicare Learning Network (MLN) Products Catalog" - Now Available
- The "Annual Wellness Visit" Podcast - Released
- "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet - Revised
- "Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record" Fact Sheet - Revised
- "The Medicare Dependent Hospital" Fact Sheet - Revised
- "The Medicare Billing Certificate Program for Part A Providers" and "The Medicare Billing Certificate Program for Part B Providers" Web-Based Training Programs - Revised

- Pilot Testers Needed
- MLN Learning Management System New Password Requirements

June 20, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-20Enews.pdf

National Provider Calls

- Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology - Register Now
- CMS National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Medicare Shared Savings Program Application Process Question and Answer Session - Register Now
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier — Register Now
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series - Save the Dates

Previous National Provider Calls: New Materials Available

- Video Slideshow Presentation from April 18 "Begin Transitioning to ICD-10 in 2013" Call Now Available
- Audio Recording and Written Transcript from May 22 "National Physician Payment Transparency Program (OPEN PAYMENTS) - What You Need To Know" Call Now Available
- Audio Recording and Written Transcript from May 30 "Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals" Call Now Available
- Audio Recording and Written Transcript from June 5 "Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier" Call Now Available

Announcements and Reminders

- National HIV Testing Day - an Annual Observance to Promote HIV Testing
- PV-PQRS: IACS Modified to Accept PTANs Less Than Ten Characters Long
- CMS Posts 2014 Eligible Professional Clinical Quality Measure Update
- New FAQs for ICD-10 Billing

Claims, Pricer, and Code Updates

- Recovery Auditor Adjustments for Periodic Interim Payment Providers

MLN Educational Products Update

- "Acute Care Hospital Inpatient Prospective Payment System" Fact Sheet - Revised
- "Ambulance Fee Schedule" Fact Sheet - Revised
- "Clinical Laboratory Fee Schedule" Fact Sheet - Revised
- New MLN Educational Web Guides Fast Fact
- Updated MLN Matters® Search Indices
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists
- Submit Feedback on MLN Educational Products

June 27, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-27Enews.pdf

MLN Connects™ National Provider Calls

- CMS National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Medicare Shared Savings Program Application Process Question and Answer Session – Register Now
- CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule – Registration Now Open

- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier – Register Now
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series – Save the Dates

Other Calls, Meetings, & Events

- Medicare Shared Savings Program Application Submission Call: Training on the Health Plan Management System
- PERM Cycle 2 Provider Education Webinar/Conference Calls

Announcements and Reminders

- Revised CMS 1500 Paper Claim Form: Version 02/12
- DMEPOS Competitive Bidding Program: July 1 Implementation- Supplier Resources
- Hospice Quality Reporting Program Reconsideration Process
- CMS Releases New FAQ Document Related to Functional Reporting of PT, OT, and SLP Services
- Reporting Period to Submit eRx Data and Avoid Adjustment Ends June 30
- PQRS Call for Measures Ends July 1
- July 3rd is an Important EHR Deadline for Medicare Eligible Hospitals and CAHs
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines
- How Will ICD-10 Affect Clinical Documentation?

Claims, Pricer, and Code Updates

- Mandatory Claims Submission Reminder for Oxygen and Oxygen Equipment Suppliers
- 2013 PQRS and/or eRx Incentive Program: Stripped N365 Remark Code

MLN Education Products Update

- "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet – Revised
- "Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Health Care Professionals Informed" Fact Sheet – Revised
- New Continuing Education Association Now Accepting Medicare Learning Network® (MLN) Courses
- New MLN Provider Compliance Fast Fact

July 4, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-04-Enews.pdf

MLN Connects™ National Provider Calls

- CMS National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Medicare Shared Savings Program Application Process Question and Answer Session – Register Now
- Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014 – Registration Now Open
- CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule – Register Now
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier – Register Now
- Medicare and Medicaid EHR Incentive Programs National Provider Call Series – Update
- ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data – Save the Date
- OPEN PAYMENTS – Policy Updates on Payments & the Physician Resource Toolkit – Save the Date

Previous MLN Connects Calls: New Materials Available

- Audio Recording and Written Transcript from June 18 "PQRS and eRx Incentive Program Payment Adjustment" Call Now Available
- Audio Recording and Written Transcript from June 20 "Medicare Shared Savings Program Application Process: Application Review" Call Now Available

Other Calls, Meetings, & Events

- Medicare Shared Savings Program Application Submission Call: Training on the Health Plan Management System Hospice Software Developer/Vendor Call

Announcements and Reminders

- Medicare Proposes Provisions for the ESRD Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
- CMS Proposes Payment Changes for Medicare Home Health Agencies for 2014
- Compare Website Redesigned to Help Consumers Search for Physicians
- Medicare Contracting Reform Website: New Name and URL Starting July 11
- Update to a 2014 eCQM Measure for Eligible Professionals
- The ICD-10 Deadline is October 1, 2014

Claims, Pricer, and Code Updates

- Additional Time to Establish Protocols for Newly Required Face-to-Face Encounters for DME
- Medicare Secondary Payment Adjustment Information
- FDG Positron Emission Tomography for Solid Tumors and Myeloma: Data Collection Ends Under the National Oncologic PET Registry
- 2014 ICD-10-CM Code Updates Now Available
- Updates to DMEPOS Competitive Bidding Program Fact Sheets: Hospital and Physician Exceptions

MLN Education Products Update

- OIG Recovery Audit Findings MLN Matters® Articles – Released
- "Health Care Professional Frequently Used Web Pages" Educational Tool – Released
- "Detailed Written Orders and Face-to-Face Encounters" MLN Matters® Article – Revised
- "Payment Related to Prior Authorization for Power Mobility Devices (PMD)" MLN Matters® Article – Revised
- "Medicare Physician Fee Schedule" Fact Sheet – Revised
- "DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet – Revised
- "DMEPOS Competitive Bidding Program: Hospitals That Are Not Contract Suppliers" Fact Sheet – Revised
- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet – Revised

July 11, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-11-Enews.pdf

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program Application Process Question and Answer Session - Register Now
- Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014 - Register Now

- Stage 1 and Stage 2 of Meaningful Use for the EHR Incentive Programs - Registration Now Open
- CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule - Register Now
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier - Register Now
- ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data - Registration Now Open
- OPEN PAYMENTS: Policy Updates on Payments and the Physician Resource Toolkit - Registration Now Open
- ICD-10 Basics - Registration Now Open
- ESRD Quality Incentive Program: Notice of Proposed Rulemaking for Payment Year 2016 - Save the Date
- Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program - Save the Date

Previous MLN Connects Calls: New Materials Available

- Audio Recording and Written Transcript from June 27 "Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology" Call Now Available

Other Calls, Meetings, & Events

- PERM Cycle 2 Provider Education Webinar/Conference Call

Announcements and Reminders

- Proposed Policy and Payment Changes to the Medicare Physician Fee Schedule for Calendar Year 2014
- CMS Proposes Hospital Outpatient and Ambulatory Surgical Centers Policy and Payment Changes for 2014
- Register to Participate in the MAC Satisfaction Indicator

Claims, Pricer, and Code Updates

- Round 2 DMEPOS Competitive Bidding Program: 120 Day Grace Period for Obtaining Written Orders
- Quarterly Update for HCPCS Code Set Now Available

MLN Education Products Update

- "Screening Pap Tests" Booklet - Reminder
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet - Reminder
- "Medicare-Covered Services Furnished Outside the United States" Fact Sheet - Now Available in Electronic Publication Format
- "ICD-10-CM/PCS Myths and Facts" Fact Sheet - Now Available in Electronic Publication Format

July 18, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-18Enews.pdf

National Provider Calls

- Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014 – Last Chance to Register
- Stage 1 and Stage 2 of Meaningful Use for the EHR Incentive Programs – Last Chance to Register
- CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule – Last Chance to Register
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier – Register Now

- ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data – Register Now
- Open Payments: Policy Updates on Payments and the Physician Resource Toolkit – Register Now
- ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 – Registration Now Open
- Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program – Registration Opening Soon
- ICD-10 Basics – Register Now

Announcements and Reminders

- How's the Service Provided by Your MAC?
- Medicare Provides Coverage for Hepatitis B for Eligible Beneficiaries
- Pioneer Accountable Care Organizations Succeed in Improving Care, Lowering Costs
- Medicare Contracting Reform Website: New Name and URL
- PV-PQRS Registration System Opening July 15
- Data Submission Deadline for the IRF and LTCH Quality Reporting Programs: August 15
- Review New and Updated FAQs on the EHR Incentive Programs

Claims, Pricer, and Code Updates

- Demand Letters to Medicare Providers and Suppliers Associated with an Item or Service Provided to Incarcerated Beneficiaries
- Final Update for ICD-9-CM Codes Now Available

MLN Educational Products Update

- New MLN Provider Compliance Fast Fact
- "Transitional Care Management Services" Fact Sheet – Released
- "Medicare Coverage of Imaging Services" Fact Sheet – Revised
- "ICD-10-CM/PCS Myths and Facts – Revised
- "ICD-10-CM/PCS The Next Generation of Coding – Revised
- "Remittance Advice Resources" Fact Sheet – Reminder
- "Remittance Advice Information: An Overview" Fact Sheet – Reminder

July 25, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-25-Enews.pdf

MLN Connects™ National Provider Calls

- How to Register to Select Your PQRS Group Reporting Option for 2013 – Last Chance to Register
- ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data – Register Now
- OPEN PAYMENTS: Policy Updates on Payments and the Physician Resource Toolkit – Register Now
- ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 – Register Now
- Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program – Registration Now Open
- ICD-10 Basics – Register Now

Other Calls, Meetings, & Events

- Special Open Door Forum: Suggested Electronic Clinical Template for Lower Limb Prostheses
- Register for the Live Webcast of the August 2nd 2013 eHealth Summit

Announcements and Reminders

- Don't Miss Your Opportunity to Rate Your MAC
- CMS Seeks Comments on Proposals to Update QIO Regulations
- Data Show Electronic Health Records Empower Patients and Equip Doctors
- CMS Announces New "OPEN PAYMENTS" Mobile Applications to Assist Physicians and Industry in Tracking Financial Relationships
- Major Improvements to the Internet-based PECOS System
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines
- Basics of PQRS & eRx Educational Videos are Available on the CMS YouTube Channel

Claims, Pricer, and Code Updates

- Update on Demand Letters and Claim Cancellations Associated with an Item or Service Provided to Incarcerated Beneficiaries
- October 2013 Outpatient Prospective Payment System Pricer File Update

MLN Education Products Update

- "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 4]" Educational Tool – Released
- "Medicare Ambulance Transports" Booklet – Revised
- "Opting out of Medicare and/or Electing to Order and Refer Services" MLN Matters® Article – Released
- New MLN Educational Web Guides Fast Fact

August 1, 2013:

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-01-enews.pdf

MLN Connects™ National Provider Calls

- ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data - Register Now
- OPEN PAYMENTS: Policy Updates on Payments and the Physician Resource Toolkit - Register Now
- ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 - Register Now
- Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program - Register Now
- ICD-10 Basics - Register Now
- Did You Miss These MLN Connects Calls?

Announcements and Reminders

- Have You Checked Your Patient's Immunization Status?
- Prescribing Specific Brands under the DMEPOS Competitive Bidding Program
- Additional Data Reporting Requirements for Hospice Claims
- Medicare Payments to Inpatient Psychiatric Facilities Are Projected to Increase 2.3 percent in FY 2014
- Dry Run of 30-day Risk-Standardized Acute Myocardial Infarction Payment Measure Begins August 5

Claims, Pricer, and Code Updates

- Claims Hold Related to Part A to Part B Rebilling of Denied Hospital Inpatient Claims
- Quarterly Provider Specific Files for the Prospective Payment System are Now Available
- July 2013 Outpatient Prospective Payment System Pricer File Update

CMS MLN CONNECTS

MLN Educational Products Update

- "Medicare-Covered Services Furnished Outside the United States" Fact Sheet - Released
- "Outpatient Therapy Functional Reporting Requirements" MLN Matters® Article - Released

DOCUMENTATION

Detailed Written Orders and Face-to-Face Encounters

MLN Matters® Number: MM8304 Revised
Related Change Request (CR) #: CR 8304
Related CR Release Date: May 31, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R468PI
Implementation Date: July 1, 2013

Note: This article was revised on June 28, 2013, to provide clarifying language on page 2 and to provide a Web address for a relevant portion of the "Program Integrity Manual" on page 2. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for certain Durable Medical Equipment (DME) items and services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8304, which instructs DME MACs to implement requirements, which are effective July 1, 2013, for detailed written orders for face-to-face encounters conducted by the physician, PA, NP or CNS for certain DME items as defined in 42 CFR 410.38(g). (That section is available at http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-38.pdf on the Internet.)

Due to concerns that some providers and suppliers may need additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act for certain items of DME, the Centers for Medicare & Medicaid Services (CMS) will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on October 1, 2013.

Section 6407 of the Affordable Care Act established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

Although many durable medical equipment suppliers and physicians are aware of and are able to comply with this policy, CMS is concerned that some may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the next several months, suppliers and physicians who order certain DME items will continue to collaborate and establish internal processes to ensure compliance with the face-to-face requirement. CMS expects durable medical equipment suppliers to have fully established such internal processes and have appropriate documentation of required encounters by October 1, 2013.

CMS will continue to address industry questions concerning the new requirements and will update information on at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/index.html on the CMS website. CMS and its contractors will also use other communication channels to ensure that the provider community is properly informed of this announcement.

Background

As a condition for payment, Section 6407 of the Affordable Care Act requires a physician to document that the physician, PA, NP or CNS has had a face-to-face encounter examination with a beneficiary in the six (6) months prior to the written order for certain items of DME (the complete list of items is found in Appendix A at the end of this article). This section does not apply to Power Mobility Devices (PMDs) as these items are covered under a separate requirement.

This includes encounters conducted via the Centers for Medicare & Medicaid Services (CMS)-approved use of telehealth (as described in Chapter 15 of the "Medicare Benefit Policy Manual" and Chapter 12 of the "Medicare Claims Processing Manual"). Those manuals are available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

Note that the date of the written order must not be prior to the date of the face-to-face encounter.

The face-to-face encounter conducted by the physician, PA, NP, or CNS must document that the beneficiary was evaluated and/or treated for a condition that supports the item(s) of DME ordered.

In the case of a DME ordered by a PA, NP, or CNS, a physician (MD or DO) must document the occurrence of a face-to-face encounter by signing/co-signing and dating the pertinent portion of the medical record. CMS will accept a single confirming signature, including the date, as sufficient if there are several pertinent portions of the medical record.

The written order for the DME must follow the guidance in the CMS "Program Integrity Manual," Chapter 5, Section 5.2.3 (available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internt-Only-Manuals-IOMs-Items/CMS019033.html) and include, at a minimum;

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

Failure to meet any of the above requirements will result in denial of the claim.

Physicians will be provided an additional payment, using code G0454, for signing/co-signing the face-to-face encounter of the PA/NP/CNS. The physician should not bill the G code when he/she conducts the face-to-face encounter. Note that the G code may only be paid to the physician one time per beneficiary per encounter, regardless of the number of covered items documented in the face-to-face encounter.

CR8304 implements these changes in Chapter 5 of the "Program Integrity Manual" to support 42 Code of Federal Regulations (CFR) 410.38(g) and the revised portion of that manual is attached to CR8304.

Additional Information

The official instruction, CR8304, issued to your DME MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R468PI.pdf on the CMS website.

Physician Documentation Responsibilities

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

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

Quarterly Update for DMEPOS Competitive Bidding Program - July 2013

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

Note: This article was revised on June 20, 2013, to list 15 new ZIP codes on page 3, instead of the previous 10 new ZIP codes. All other information remains the same.

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8232 to provide the DMEPOS July 2013 quarterly update. Change Request (CR) 8232 provides specific instructions for implementing updates to the DMEPOS Competitive Bidding Program (CBP) Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

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

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

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

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

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

MIPPA required the competition for Round Two to occur in 2011 in 70 additional Metropolitan Statistical Areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

More information on Round Two is also available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet. The information at this site includes Round Two and National Mail Order information, the latest product categories in the CBP, single payment amounts, and the ZIP codes of areas impacted by the CBP.

Updates to the ZIP Code Files

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

ZIP	CBA
22350	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
31144	20075 - Atlanta-Sandy Springs-Marietta, GA
35270	20110 - Birmingham-Hoover, AL
40166	20290 - Louisville/Jefferson County, KY-IN
46197	20250 - Indianapolis-Carmel, IN
46213	20250 - Indianapolis-Carmel, IN
56935	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
56967	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
56999	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
64162	28140 - Kansas City, MO-KS
72255	20280 - Little Rock-North Little Rock-Conway, AR
80038	20185 - Denver-Aurora-Broomfield, CO
84129	20430 - Salt Lake City, UT
85633	20510 - Tucson, AZ
87070	20060 - Albuquerque, NM

Additional Information

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

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

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

DOCUMENTATION

Use of a Rubber Stamp for Signature

MLN Matters® Number: MM8219
Related Change Request (CR) #: CR 8219
Related CR Release Date: May 17, 2013
Effective Date: June 18, 2013
Related CR Transmittal #: R465PI
Implementation Date: June 18, 2013

Provider Types Affected

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

What You Need to Know

For medical review purposes, the Centers for Medicare & Medicaid Services (CMS) requires that services ordered/provided be authenticated by a handwritten or electronic signature. With few exceptions, stamped signatures are not acceptable as described in Chapter/Section 3.3.2.4 of the "Medicare Program Integrity Manual." Change Request (CR) 8219 adds another exception to that manual. Under the added exception, CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

Additional Information

The official instruction, CR8219 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R465PI.pdf on the CMS website.

DRUGS AND BIOLOGICALS

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

MLN Matters® Number: MM8340
Related Change Request (CR) #: CR 8340
Related CR Release Date: May 31, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2715CP
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (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) 8340 which instructs Medicare contractors to download and implement the October 2013 Average Sales Price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2013, April 2013, January 2013, and October 2012 ASP

drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 7, 2013, with dates of service October 1, 2013, through December 31, 2013. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA) Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The Average Sales Price (ASP) methodology is based on quarterly data 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 OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website.)

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

Files	Effective Dates of Service
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

Additional Information

The official instruction, CR8340 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2715CP.pdf on the CMS website.

Documentation Reminders: Immunosuppressive Drugs

Claims review by both the DME MACs and the Comprehensive Error Rate Testing (CERT) Review Contractor show a high percentage of documentation errors involving claims for immunosuppressive drugs. As a result many of the DME MACs are, or will be, conducting a review of immunosuppressive drug claims. Some of the most common errors identified by claim reviewers relate to physician records including:

Detailed Written Orders

- Copy of detailed written order was not provided;
- Detailed written order was illegible (blackened and/or blurred)
- The order was invalid because it was missing required elements. Required elements for orders include:
  - Beneficiary's name
  - Name of drug
  - Dosage
  - Quantity to be dispensed
  - Route of administration

- Frequency of administration
- Physician's name
- Refill instructions
- Physician signature and date
- The start date of the order – only required if the start date is different than the signature date

- Physician did not personally date his/her signature; and
- Items were delivered prior to obtaining a detailed written order and no written documentation of a dispensing order was provided.

Medical Records

- Copy of pertinent medical records was not provided;
- Medical records did not document that the drug was included in the physician's plan of care for the beneficiary;
- Records failed to document continued use and/or medical need for the drug;
- The name of the transplant center was not provided;
- Records are missing a signature or it is illegible; and
- Records provided did not document a transplant.

Physicians are reminded that while immunosuppressive drugs are often prescribed for various medical indications, Medicare's coverage of immunosuppressive drugs is narrowly defined and closely regulated by Medicare statute and benefit category language. Title XVIII of the Social Security Act, §1861(s)(2)(J) provides for coverage of immunosuppressive drugs; however, coverage is limited solely to usage following specific organ transplants. Regulations regarding coverage and payment of immunosuppressive drugs are found in 42 CFR 410.30 and the Centers for Medicare & Medicaid Services (CMS) Benefit Policy Manual (Internet-Only Manual, Publication 100-2), Chapter 15, Section 50.5.1 and Claims Processing Manual (Internet-Only Manual, Publication 100-4), Chapter 17, Section 80.3.

As a result of the statutory and benefit language, immunosuppressive drugs are eligible for reimbursement only when all of the following criteria are met:

1. Immunosuppressive drugs are prescribed following either:
   - Kidney (V42.0), heart (V42.1), liver (V42.7), bone marrow (V42.81)/stem cell (V42.82), lung (V42.6), or heart/lung (V42.1 and V42.6) transplant; or,
   - Whole organ pancreas (V42.83) transplant performed concurrent with or subsequent to a kidney transplant (V42.0) because of diabetic nephropathy (performed on or after July 1, 1999); or,
   - Intestinal transplant (V42.84) (performed on or after April 1, 2001); or,
   - Pancreatic islet cell transplant (V42.89) or partial pancreatic tissue transplantation (V42.89) performed on or after October 1, 2004 that is conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial; or,
   - Pancreas transplants alone (performed on or after April 26, 2006) that meet the following criteria:
     - The transplant is performed in a facility that is Medicare-approved for kidney transplantation; and
     - Beneficiary must have a diagnosis of type I diabetes and:
       - Must be beta cell autoantibody positive; or,
       - Must demonstrate insulinopenia, (fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method). A fasting glucose must be obtained when performing a fasting C-peptide determination. Fasting C-peptide levels are considered valid when a concurrently obtained fasting glucose is ≤225 mg/dL; and,

- Must have a history of labile (brittle or medically-uncontrollable) insulin-dependent diabetes mellitus resulting in documented recurrent, severe, acutely life-threatening metabolic complications requiring hospitalization(s). Complications may include frequent hypoglycemia where the beneficiary is unaware, recurring severe ketoacidosis, or recurring severe hypoglycemic attacks; and,
- Must have been under the care of an endocrinologist and have clinical documentation denoting optimal and intensive management was provided for at least 12 months, having received the most medically-recognized advanced insulin formulations and delivery systems; and,
- Must demonstrate being able to emotionally and mentally understand the significant risks associated with surgery and be able to effectively manage the lifelong need for immunosuppression; and,
- Must otherwise be a suitable candidate for transplantation; and

2. The transplant met Medicare coverage criteria in effect at the time (e.g., approved facility for kidney, heart, intestinal, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria; etc.); and,
3. The beneficiary was enrolled in Medicare Part A at the time of the transplant; and,
4. The beneficiary is enrolled in Medicare Part B at the time that the drugs are dispensed; and,
5. The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.

If criteria 1–5 are not met, the drug(s) will be denied as noncovered.

If criteria 1, 2, and 3 are met, the transplant is considered a "covered transplant" for purposes of this policy whether payment for the transplant was made by Medicare or by another insurer. For questions regarding documentation requirements for Immunosuppressive Drug claims, physicians and suppliers should refer to the Immunosuppressive Drugs LCD and related Policy Article for their respective DME MAC.

Incorrect Number of Units Billed for Rituximab (HCPCS J9310) and Bevacizumab (HCPCS C9257 and J9035) – Dose versus Units Billed

MLN Matters® Number: SE1316 Revised

Note: This article was revised on August 1, 2013, to add the section on "Supplemental Information on Reporting Drugs" that begins on page 3.

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and nonphysician practitioners who bill Medicare for rituximab (Rituxan®) and bevacizumab (Avastin®). The purpose of the article is to remind providers how to properly compute the units of rituximab and bevacizumab that should be billed to Medicare.

What You Need to Know

This article informs you that the Recovery Auditors conducted complex reviews of claims billed for rituximab and bevacizumab. According to the Healthcare Common Procedure Coding System (HCPCS), rituximab is coded as J9310 and bevacizumab is coded as C9257 or J9035. Recovery Auditors reviewed medical records to verify the exact number of milligrams (mg) administered and identify the correct number of units that should have been billed to Medicare.

Please remember to verify the milligrams given to the patient and then convert to the proper units for billing. When the Recovery Auditors reviewed medical records, the common billing error was forgetting to convert milligrams to units.

To accurately bill for rituximab and bevacizumab, it is very important that providers instruct their billing staff to verify the milligrams given, convert to the proper units for billing, and ensure the quantity administered is consistent with the units billed. Providers should differentiate between unit billing versus milligram billing on these high cost drugs.

The following are key points to remember when billing Medicare for rituximab (J9310)

- J9310 is defined in the HCPCS manual as: Injection, rituximab, 100 mg
- One (1) unit represents 100 mg of rituximab ordered/administered per patient
- Rituximab should be billed based on units
    - For example, if the quantity administered is 200 mg and the description of the drug code is 100 mg, the units billed should be two (2)

The following are key points to remember when billing Medicare for bevacizumab (J9035 or C9257):

- C9257 is defined in the HCPCS manual as: Injection, bevacizumab, 0.25 mg
- J9035 is defined in the HCPCS manual as: Injection, bevacizumab, 10 mg
- One (1) unit represents 10 mg of (J9035) or 0.25 mg (C9257) of bevacizumab ordered/administered per patient
- Bevacizumab should be billed based on units, not the total number of milligrams
    - For example, if the quantity administered is 300mg and the description of the drug code is 10 mg, the units billed should be thirty (30)

Examples of Findings

Rituximab (Rituxan®)

1. For date of service 10/27/2009, the provider billed J9310 for 71 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 7,100 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 710 mg and the provider billed an incorrect number of units. The correct units should be 7.1 units; however, this would be rounded up to 8 units for billing purposes.
2. For date of service 04/29/2010, the provider billed J9310 for 100 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 10,000 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 1,000 mg and the provider billed an incorrect number of units. The units were adjusted down to 10 units to reflect the proper dosage amount given.

Bevacizumab (Avastin®)

1. A provider billed code J9035 for 1,300 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 13,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 13,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,300 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 130 units.
2. For date of service 10/6/2010, the provider billed code J9035 for 1,600 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 16,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 16,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,600 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 160 units.

Supplemental Information Related to Reporting Drugs

The following serves to clarify billing guidelines and provide examples of proper billing with a single-dose vial and discarded drug billing:

- Providers and hospitals are reminded to ensure that amounts of drugs administered to patients are accurately reported in terms of the dosage specified in the long descriptors for the applicable HCPCS codes. This is because the short descriptors are limited to 28 characters so they do not always capture the complete description of the drug.
- When submitting Medicare claims, units should be reported in multiples of the dosage included in the long HCPCS descriptor. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the number as a multiple.

- If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Medicare may cover the amount of the drug discarded along with the amount administered. The following elements must be followed in order for the discarded amount to be covered.
    1. The vial must be a single-use vial. Multi-use vials are not subject to payment for any discarded amounts of the drug
    2. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient
    3. The left-over amount must actually be discarded and may not be used for another patient regardless of whether or not that other patient has Medicare
- Please clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain. This kind of detailed documentation helps benefit your practice by justifying your billing in the event a medical review should occur.
- If your Medicare contractor requires discarded drugs to be reported with the JW modifier on a separate line, the total number of discarded units reported should not include amounts of the drug also included on the administered line due to the rounding up of units (see examples below).
- Please remember to verify the milligrams given to the patient and then convert to the proper units for billing

Hypothetical Examples

- Rituximab (Rituxan®)
    - Rituxan® is supplied as 100 mg/10 mL and 500 mg/50 mL solution in single-use vials
    - The physician administers 80 mg of rituximab to a patient. The smallest-sized vial available for this dose is 100 mg. The physician uses the 100 mg vial to administer 80 mg. The physician discards the remaining 20 mg in the vial.
    - Since the J9310 long descriptor for rituximab (Rituxan®) shows that 1 billing unit represents 100 mg ordered/administered per patient, the correct calculation of units would be 0.8 units (80/100). However, for billing purposes, this would be rounded up to 1 unit.
    - In this example, billing for 100 units would be an error. Since J9310 is defined as 1 unit being equal to 100 mg, this would mean that the patient received an unlikely dosage of 10,000 mg of rituximab for that date of service.
    - Due to the single-use vial type, the provider may bill for the amount administered as well as the amount appropriately discarded. The discarded amount is reported with the JW modifier. The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. (See the "Medicare Claims Processing Manual," Chapter 17, Section 40 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf on the CMS website.) For example, one billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a patient while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would be processed for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.
- Bevacizumab (Avastin®)
    - Avastin® is supplied as 100 mg/4 mL and 400 mg/16 mL solution in single-use vials
    - The physician administers 395 mg of bevacizumab to a patient. The smallest- sized vial available for this dose is 400 mg. The physician uses the 400 mg vial to administer 395 mg. The physician discards the remaining 5 mg in the vial.

- Since the J9035 long descriptor for bevacizumab (Avastin®) shows that 1 billing unit represents 10 mg ordered/administered per patient, the correct calculation of units would be 39.5 units (395/10). However, for billing purposes, this would be rounded up to 40 units.
- In this example, billing for 395 units would be an error. Since J9035 is defined as 1 unit being equal to 10 mg, this would mean that the patient received 3,950 mg of bevacizumab for that date of service. This would be a billing error.
- Due to the single-use vial type, the provider may bill for the amount administered as well as the amount appropriately discarded

Additional Information

Links to additional resources:

National coverage determination (NCD) for bevacizumab

- http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
- Document ID: 110.17

Supplementary MLN Matters® articles:

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3419.pdf
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3742.pdf

Alpha-Numeric HCPCS codes:

- http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

JW HCPCS Modifier Information:

- http://www.wpsmedicare.com/part_b/resources/modifiers/modifier-jw.shtml
- http://www.palmettogba.com/palmetto/providers.nsf/vmasterdid/8eelbr2808
- http://www.cgsmedicare.com/parta/pubs/news/2012/1112/786.html

Medicare Manual References:

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

2013 Medicare Part B Drug Average Sales Price:

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2013ASPFiles.html

Infusion Pump Denied/Accessories & Drug Codes Should Be Denied

MLN Matters® Number: SE1327

Provider Types Affected

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

Provider Action Needed

Durable Medical Equipment suppliers who submit claims for infusion pumps need to know the billing requirements for infusion accessories and drugs.

When the infusion pump is denied, then the infusion accessories and infusion drugs are also denied.

Background

This article is based on the results of an automated review of claims for infusion pumps, accessories and drugs by the Recovery Auditors. When claims for infusion pumps are denied, claims for infusion accessories and for infusion drugs related to the denied pump should also be denied.

Here are two examples of incorrect billings:

- A 73 year-old male was denied an E0784 (Insulin external ambulatory infusion pump) on April 5, 2007

  The same patient was then allowed 13 units of A4221 (supplies for maintenance of drug infusion catheter) and 30 units of K0552 (supplies for external drug infusion pump, syringe type cartridge) on April 5, 2007.

  No paid claims exist for the E0784 within the same rental month as the A4221 and K0552. Per Local Coverage Determination (LCD) 11570, supplies are covered if the related pump is covered. Therefore, the 13 units of A4221 and the 30 units of K0552 are overpaid for April 5, 2007.

- A 63 year-old female was denied an E0784 (Insulin external ambulatory infusion pump) on September 7, 2007

  The same patient was then allowed 3 units of A4221 (supplies for maintenance of drug infusion catheter) on September 30, 2007

  No paid claims exist for the E0784 within the same rental month as the A4221. Per LCD 11570, supplies are covered if the related pump is covered. Therefore, the 3 units of A4221 are overpaid for September 30, 2007.

How You Can Improve Your Billing

You are encouraged to review the following documents in the Local Coverage Determinations section of the Medicare Coverage Database:

- "External Infusion Pumps" addresses coverage indications, limitations, and medical necessity, coding and general information. Please find this document, updated 2/17/2013, posted by your DME MAC (L11555, L2745, L5044 or L11570), at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the Centers for Medicare & Medicaid Services (CMS) website.
- "External Infusion Pumps," policy article, effective 1/1/ 2013, discusses non-medical necessity coverage and payment rules and coding guidelines. This document, updated 3/15/2013, posted by your DME MAC (A20210, A47226, A19713, or A19834), is available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website.
- The "Medicare National Coverage Determinations Manual," Chapter 1, Part 4, Coverage Determinations, Section 280.14, Infusion Pumps discusses coverage of external infusion pumps and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf on the CMS website.

Seventh 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 seventh quarter edit effectiveness results from March 2013 through June 2013 are as follows:

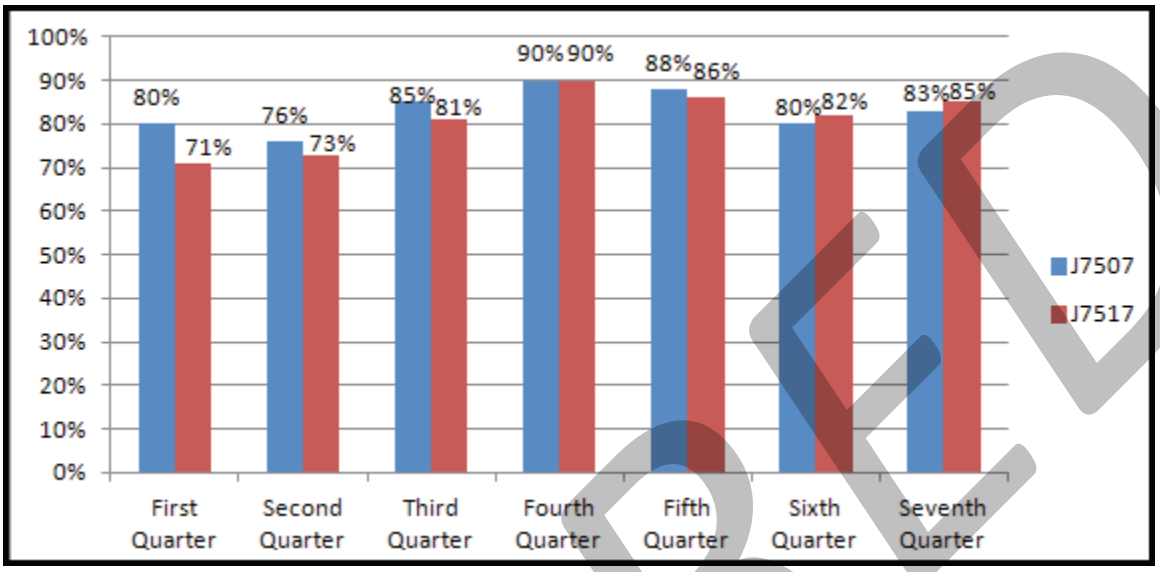
The J7507 review involved 4,209 claims of which 3,593 were denied. This resulted in an overall error rate of 83%.

The J7517 review involved 2,599 claims of which 2,276 were denied. This resulted in an overall error rate of 85%.

The J7518 review involved 1,659 claims of which 1,338 were denied. This resulted in an overall error rate of 78%.

The J7520 review involved 500 claims of which 437 were denied. This resulted in an overall error rate of 84%.

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



Primary Documentation Errors that Resulted in Denial of Claims

- 67% of J7507 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines
- 67% of J7517 claims received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines
- 58% of claims J7518 received a denial as requested documentation was not provided within the allotted time frame as referenced in the Medicare Guidelines
- 63% of claims J7520 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.

- 18% of J7507 claims received a denial as there was no/invalid refill request
- 19% of J7517 claims received a denial as there was no/invalid refill request
- 18% of J7518 claims received a denial as there was no/invalid refill request
- 16% of J7520 claims received a denial as there was no/invalid refill request

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 [hereinafter pim108c5, §5.2.5]) and pim108c5, §5.2.6).

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

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a 1-month quantity at a time (clm104c17, §80.3).

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

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies, i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) - the supplier should assess the quantity of each item that the beneficiary still has remaining, to document that the amount remaining will be nearly exhausted on or about the supply anniversary date
- 6% of J7507 claims received a denial as there was no proof of delivery submitted
- 7% of J7517 claims received a denial as there was no proof of delivery submitted
- 6% of J7518 claims received a denial as there was no proof of delivery submitted
- 7% of J7520 claims received a denial as there was no proof of delivery submitted

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

Method 1–Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

- Beneficiary's name

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

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

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

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

- 5% of J7507 claims received a denial as there was no detailed written or dispensing order submitted
- 5% of J7517 claims received a denial as there was no detailed written or dispensing order submitted
- 5% of J7518 claims received a denial as there was no detailed written or dispensing order submitted
- 7% of J7520 claims received a denial as there was no detailed written or dispensing order submitted

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request.

DISPENSING ORDERS (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

DETAILED WRITTEN ORDERS (PIM 5.2.3)

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

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

- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

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

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

Going Forward

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

Education Resources

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

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

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

2013 Ask the Contractor Teleconferences

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

Upcoming 2012 ACT: 3 p.m. CT

Date	Topic
10/17/2013	General
11/19/2013	Appeals

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

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

CMS National Physician Payment Transparency Program: Open Payments Training Module for Providers

Participants of this training module will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

Background

On February 8, 2013, the Centers for Medicare & Medicaid Services (CMS) published a final rule that is intended to increase public awareness of financial relationships between manufacturers of drugs, devices, biologicals and medical supplies, as well as between applicable Group Purchasing Organizations (GPOs), and physicians and teaching hospitals. Known as the "National Physician Payment Transparency Program: Open Payments," this is one of many steps in the Affordable Care Act designed to create greater transparency in the health care market.

Applicable manufacturers of covered drugs, devices, biologicals, and medical supplies must report payments or other transfers of value to physicians and teaching hospitals to CMS. Applicable manufacturers and applicable GPOs must also report certain ownership or investment interests held by physicians or immediate family members. Applicable GPOs must report to CMS payments or other transfers of value made to physician owners or investors if they held ownership or an investment interest at any point during the reporting year.

CMS will collect the data annually, aggregate it, and publish it on a public Website. Applicable manufacturers and applicable GPOs must begin to collect the required data on August 1, 2013 and report the data collected through December 31, 2013 to CMS by March 31, 2014.

Continuing Medical Education Activity Available

CMS has produced a training module called "Are You Ready for the National Physician Payment Transparency Program?" Accessible via Medscape (http://www.medscape.org/viewarticle/780900?src=cmsaca), and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of www.medscape.com.

Web-Based Workshop Registration New Feature – Add Event to Your Calendar

Noridian wants to make it easier for you to remember upcoming web-based workshop events. A new feature has been added to the registration confirmation e-mails allowing certain e-mail users to add the event to their e-mail calendar.

The registration process has not changed but once an attendee has registered for a web-based workshop on the Noridian webpage, a confirmation email comes from messenger@webex.com. Within that confirmation e-mail, the attendee should watch for the attachment for this new feature. The attachment contains a calendar invite that you can accept in order for the event to be added to the calendar of that e-mail account. Thank you for your attendance at web-based workshops.

* This feature is not available for all email accounts

EDUCATIONAL

You Can Help Determine Topics for In-Person Seminar Roundtables

Noridian has created a survey for suppliers to complete when planning to attend one of our upcoming in-person seminars. The survey will help Education staff plan for topics to discuss at our breakout roundtable sessions.

The survey is quick and easy with only two questions. Plus, it will help to ensure the specialties you would like to discuss are highlighted at the seminar.

Please visit our In-Person Seminar webpage and click on the survey link for the event you plan to attend.

Thank you in advance for your input!

ENROLLMENT

Enrollment Denials When Overpayment Exists

MLN Matters® Number: MM8039 Rescinded
Related Change Request (CR) #: CR 8039
Related CR Release Date: May 31, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R469PI
Implementation Date: October 7, 2013

Note: This article has been rescinded due to the related CR being rescinded. The CR and article will be replaced at a later date.

Additional Information

The official instruction, CR8039, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R469PI.pdf on the CMS website.

ENTERAL NUTRITION

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes B4150. The first quarter edit effectiveness results from February 2013 through May 2013 are as follows:

The B4150 review involved 96 claims of which 92 were denied. This resulted in an overall error rate of 97%.

Primary Documentation Errors that Resulted in Denial of Claims

- 17% of B4150 claims received a denial as the refill requirements were not met

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

(CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6).

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

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one (1) month quantity at a time.

Supply allowance HCPCS codes (B4034-B4036) are daily allowances which are considered all inclusive and therefore refill requirements are not applicable to these HCPCS codes. Refer to the Coding Guidelines section in the Policy Article for further clarification.

- 15% of B4150 claims received a denial as no documentation was provided in response to the additional documentation request

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

- 9% of B4150 claims received a denial as the physician order submitted has incomplete or missing elements

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

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

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

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

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

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

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

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

The dispensing order must be available upon request.

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

- 7% of B4150 claims received a denial as the proof of delivery provided was invalid

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

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

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

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

Suppliers are required to maintain POD documentation in their files. For items addressed in this policy there are three methods of delivery:

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

Going Forward

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

Education Resources

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

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

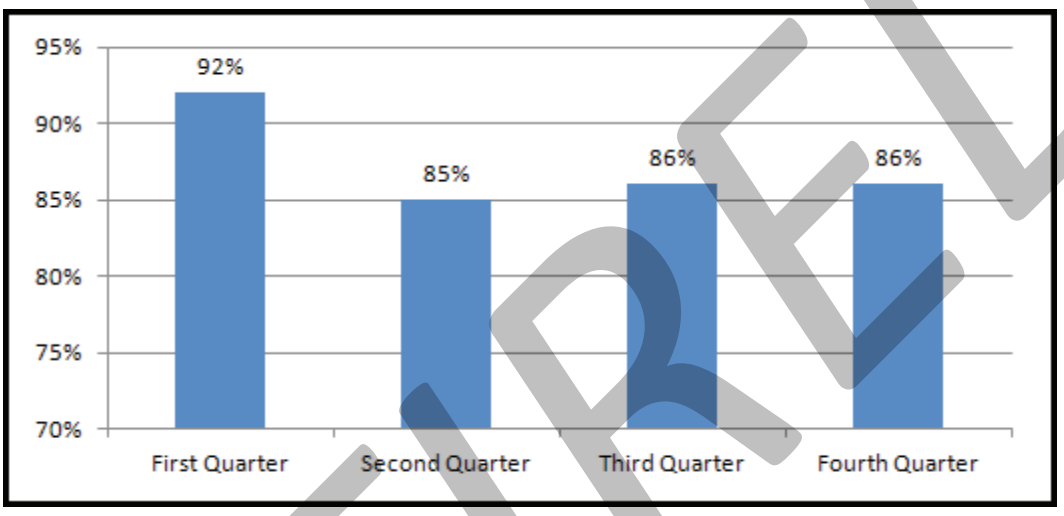
Fourth Quarter Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4035)

Current Review Results

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

The B4035 review involved 1,144 claims of which 979 were denied. This resulted in an overall error rate of 86%.

Historical Data of the Error Rate for B4035 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 23% of B4035 claims received a denial as the refill requirements were not met for the corresponding nutrition resulting in the kits being denied

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

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

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

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

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

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

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

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

If the coverage requirements for enteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered.

- 15% 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.

- 10% of B4035 claims received a denial as the proof of delivery was invalid or no proof of deliver was received

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

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

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

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

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

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

- 7% of B4035 claims received a denial as the physician order submitted has incomplete or missing elements

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

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

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

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

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

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

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

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

The dispensing order must be available upon request.

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

Going Forward

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

Education Resources

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

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

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

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

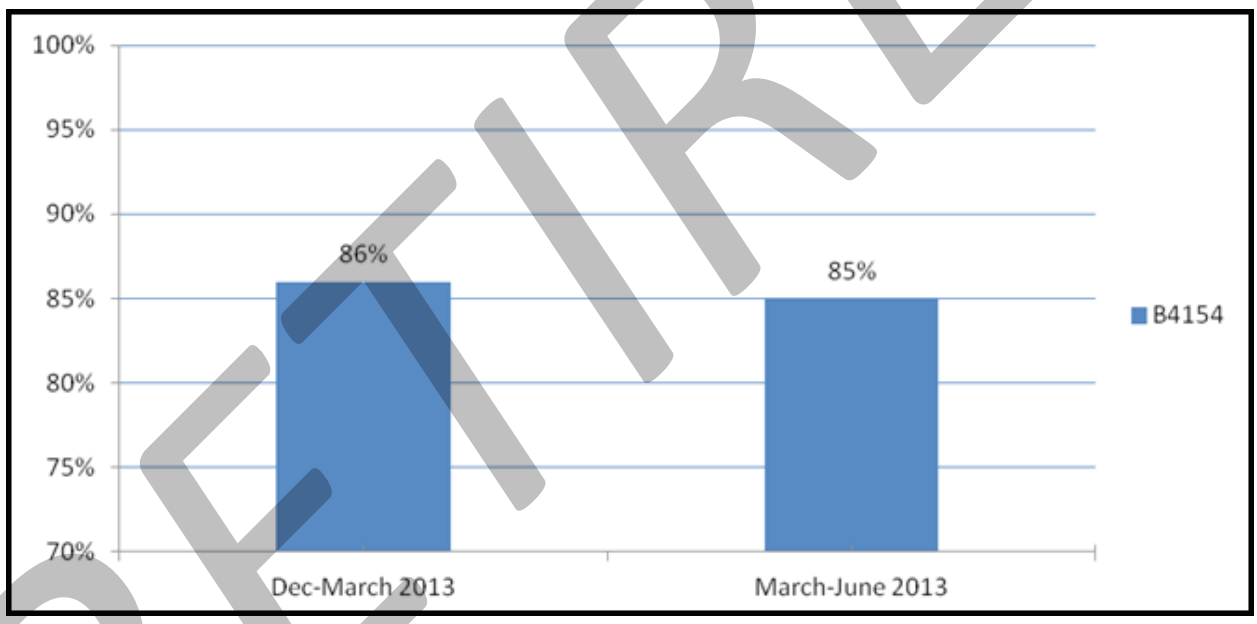
Second Quarter Results of Widespread Prepayment Review of Claims for Enteral Nutrition (HCPCS B4154)

Current Review Results

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

The B4154 review involved 1,153 claims of which 1,004 were denied. This resulted in an overall error rate of 85%.

Historical Data of the Error Rate for B4154 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 22% 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.

- 19% of B4154 claims received a denial as no documentation was received

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

- 9% of B4154 claims received a denial as the proof of delivery was invalid

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

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

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

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

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

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

- 6% of B4154 claims received a denial as the physician order is incomplete or was missing elements.

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

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

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

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

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

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

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

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

The dispensing order must be available upon request.

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

Going Forward

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

Education Resources

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

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

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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.

Documentation Reminder – Glucose Monitor Logs for High-Utilization Claims

The Home Blood Glucose Monitor LCD requires that certain information be documented for beneficiaries testing at high frequency. One key item is evidence that the beneficiary is actually testing at the prescribed high frequency. Numerous methods may be used to gather this information. One common method has been for the DMEPOS supplier to collect the beneficiary testing logs.

In the past, the DMEPOS supplier was allowed to directly collect testing logs from the beneficiary and submit them to the DME MAC when requested as part of a claim review. In November 2012, the Home Blood Glucose Monitor LCD was revised, eliminating the option for the DMEPOS supplier to directly collect the testing log. This option was removed as it violates the CMS Program Integrity Manual (PIM) section 5.7 requirement for documentation of medical necessity. The section specifies that information justifying coverage must be part of the medical record. This section explicitly excludes DMEPOS supplier collected information from being sufficient alone to justify coverage, even if signed by the physician. Supplier collected information, even if signed by the physician must be corroborated by information directly contained in the medical record. PIM 5.7 says, in relevant part:

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).

The November 2012 LCD was revised to remove statements in previous versions of the policy allowing for direct supplier collection of testing logs. The current LCD INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY section now states:

High Utilization

- For a beneficiary who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a) – (c) below are met
- For a beneficiary who is currently being treated with insulin injections, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a) – (c) below are met

  a. Basic coverage criteria (1) – (2) listed above for all home glucose monitors and related accessories and supplies are met; and,

  b. The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary; and,

  c. 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.*

Note: that there is now NO mention of the supplier collection of testing logs. The requirement is that the evidence of beneficiary testing must be in the medical record.

The POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section states:

Additional documentation requirements apply to:

- A beneficiary who is not insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day; or,
- A beneficiary who is insulin-treated (KX modifier present) and whose prescribed frequency of testing is more often than three times per day

Additional documentation in the medical record must demonstrate that the basic coverage criteria (1) – (2) described in the Indications and Limitations of Coverage and/or Medical Necessity section of this LCD have been met and that the additional criteria (a) – (c) for high utilization have been met, including the evaluation of the beneficiary's glucose control necessitating quantities of test strips and lancets that exceed the usual utilization guidelines (criterion b). This information does not have to be submitted with the claim but must be available upon request.

In summary, (1) DMEPOS suppliers may not directly collect beneficiary testing information (logs) and submit them to the DME MAC to demonstrate compliance with this criterion and (2) DMEPOS suppliers may not directly collect beneficiary testing information (logs) and forward it to the treating physician for inclusion into the medical record to demonstrate compliance with this requirement.

Refer to the Glucose Monitors LCD, related Policy Article and Supplier Manual for additional information.

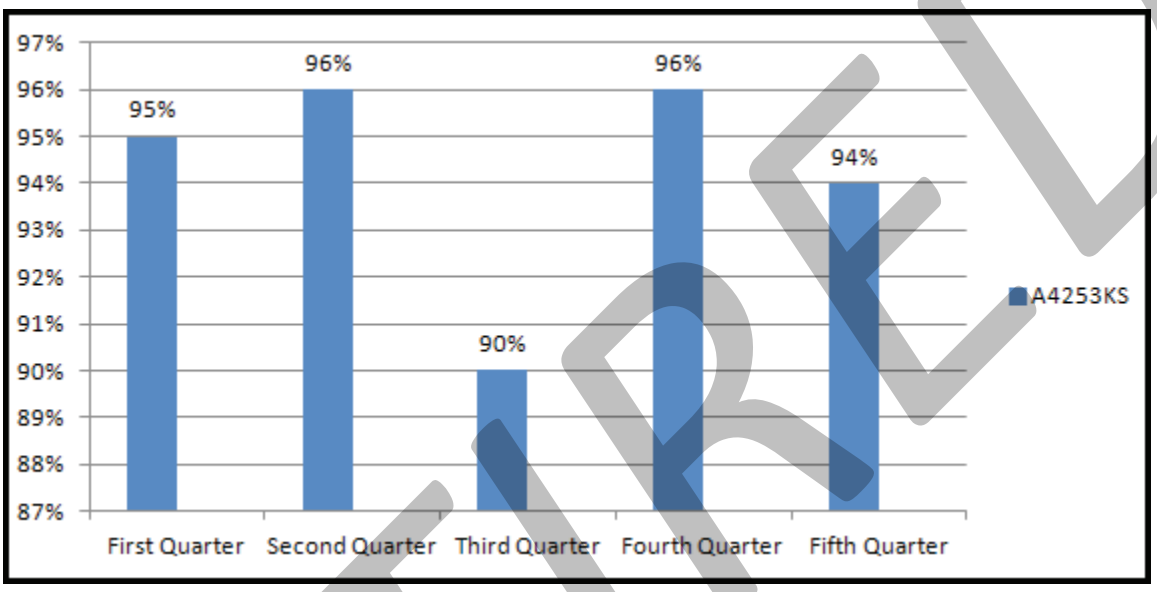
Fifth Quarter Results of Widespread Prepayment Review of Claims for Glucose Monitors (HCPCS A4253KS)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A4253KS. The fifth quarter edit effectiveness results from 04/04/13 through 07/03/13 are as follows:

The A4253KS review involved 3419 claims, of which 3382 were denied. This resulted in an overall error rate of 94%.

Historical Data of the Error Rate for A4253KS Review



Primary Documentation Errors that Resulted in Denial of Claims

- 18% of A4253KS claims received a denial as no documentation received

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

- 18% of A4253KS claims received a denial as documentation does not support the actual testing frequency that corroborates with the quantity of supplies that have been dispensed

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

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

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

- 9% of A4253KS claims received a denial as the refill requirements have not been met

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

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

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

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

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

Going Forward

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

Education Resources

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

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

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

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

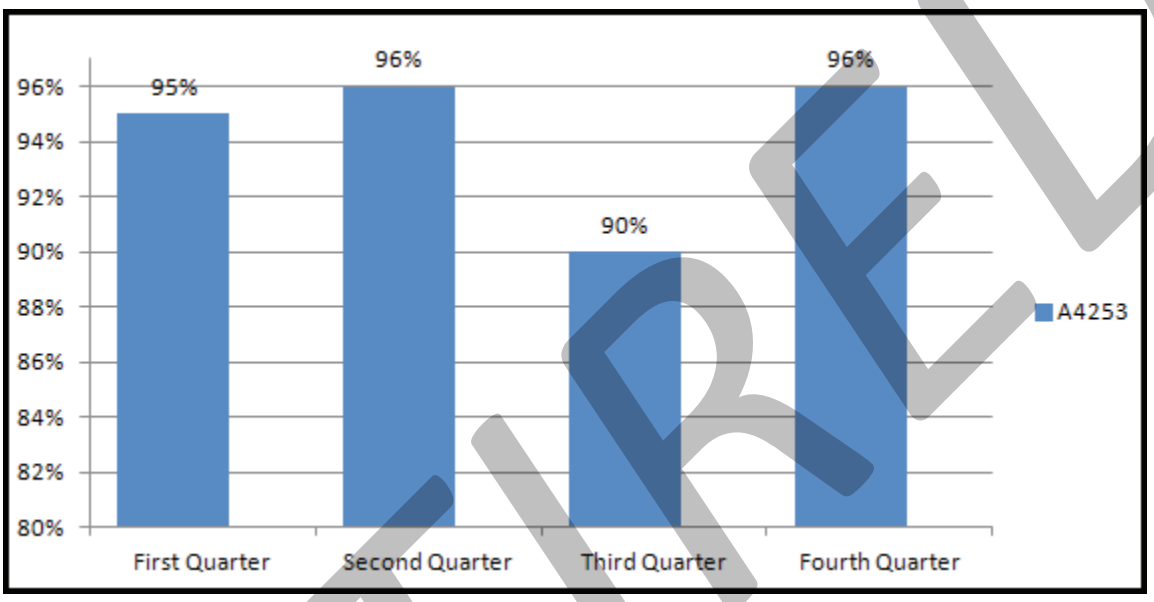
Fourth Quarter Results of Widespread Prepayment Review of Claims for Glucose Monitors (HCPCS A4253KS)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes A4253KS. The fourth quarter edit effectiveness results from January 2013 through March 2013 are as follows:

The A4253KS review involved 3,586 claims of which 3,535 were denied. This resulted in an overall error rate of 96%.

Historical Data of the Error Rate for A4253KS Review



Primary Documentation Errors that Resulted in Denial of Claims

- 18% of A4253KS claims received a denial as no documentation was received

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

- 16% of A4253KS claims received a denial as documentation does not support the actual testing frequency that corroborates with the quantity of supplies that have been dispensed

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

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

- 15% of A4253KS claims received a denial as the medical records do not support the specific reason for the additional materials for the particular beneficiary

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

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.

- 10% of A4253KS claims received a denial as the refill requirements have not been met

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

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

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

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

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Glucose Monitor on the Noridian 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 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.

Glucose Monitors and Supplies Letter to Physicians

A letter intended to provide physicians with guidance on Medicare's coverage and documentation requirements for glucose monitors and testing supplies is provided at https://www.noridianmedicare.com/dme/news/docs/2013/07_jul/glucose_monitors_and_supplies.html.

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code A4253. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from March 2013 through May 2013, resulted in an overall error rate of 75%.

Primary Documentation Errors that Resulted in Denial of Claims

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

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

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

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization.

Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients.

Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three (3)-month quantity at a time.

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

The documentation submitted did not support the actual testing frequency that corroborates the quantity of supplies that were dispensed.
For services performed prior to 11/01/12 – If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

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

that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

The order submitted was invalid.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

GLUCOSE MONITORS

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

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

The DWO must be available upon request.

Going Forward

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

Education Resources

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

Glucose Monitors

Local Coverage Determination L196

Policy Article A33673

National Coverage Determination 40.20

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

- Documentation Checklists
- Physician Resource Letters
- Policy Specific Training/Events

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

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

HOSPITAL BEDS

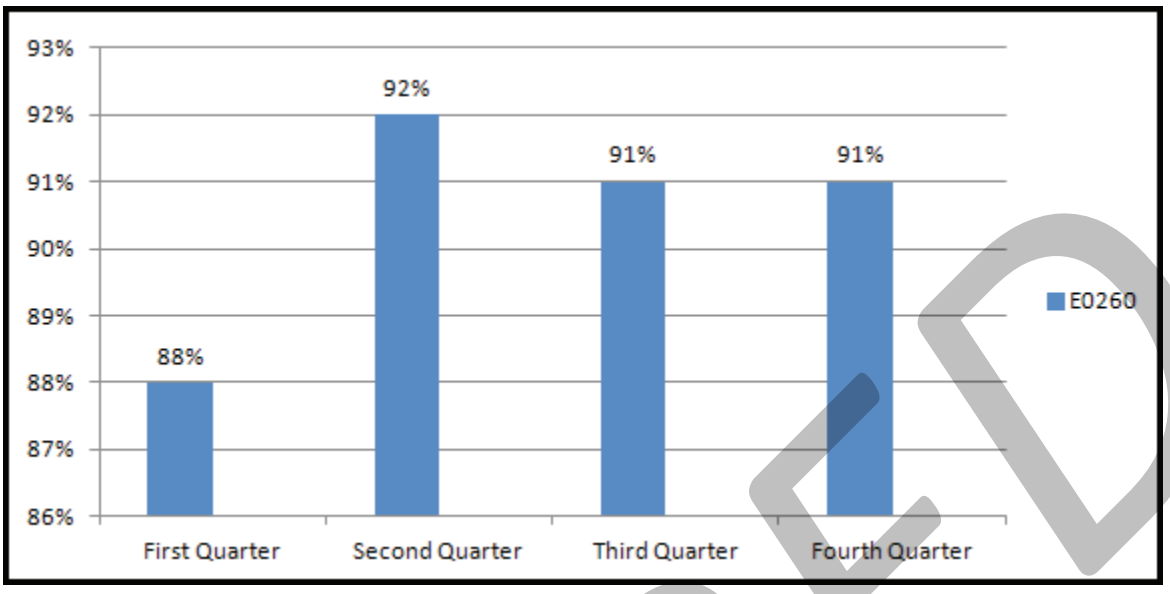
Fourth Quarter Results of Widespread Prepayment Review of Claims for Hospital Beds (HCPCS E0260)

Current Review Results

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

The E0260 review involved 4,806 claims of which 4,308 were denied. This resulted in an overall error rate of 91%.

Historical Data of the Error Rate for E0260 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 26% of E0260 claims received a denial as the medical documentation submitted did not support the criteria for a fixed height bed
- 24% of E0260 claims received a denial as the medical documentation submitted did not support the criteria for a semi-electric bed

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

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.

- 13% of E0260 claims received a denial as no documentation was provided in response to the additional documentation request
- 7% of E0260 claims received a denial as no medical records were provided

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

Going Forward

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

Education Resources

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

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

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

LCD for Hospital Beds and Equipment – Documentation Reminder

The Comprehensive Error Rate Testing (CERT) Contractor reviews claims and identifies errors in compliance with Medicare payment rules. These errors are reported as the CERT Error Rate. The DME MACs provide information about these errors and actions that may be undertaken to reduce or avoid them.

The highest volume of CERT errors occurring for hospital beds and equipment claims are due to missing or incomplete documentation to demonstrate that the following LCD reasonable and necessary (R&N) criteria were met:

A fixed height hospital bed (E0250, E0251, E0290, E0291, and E0328) is covered if one or more of the following criteria (1–4) are met:

1. The beneficiary 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 beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The beneficiary 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, or
4. The beneficiary requires traction equipment, which can only be attached to a hospital bed

A variable height hospital bed (E0255, E0256, E0292, and E0293) is covered if the beneficiary meets one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the beneficiary 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.

As these are rental items, there must be evidence of continued medical need and on-going medical management periodically (within 12 months of the date of service) noted in the medical record in order to document sufficient physician oversight of the underlying medical conditions to justify continued rental reimbursement.

Information from the medical record is necessary to provide evidence that the policy requirements are met. This means that DMEPOS suppliers must develop effective communication with their referral sources to ensure that the policy requirements are understood and sufficient information is recorded to justify payment.

The DME MACs have developed a "Dear Physician" letter describing Medicare's documentation requirements. This letter is available on each DME MAC web site. In addition, we suggest that furnishing a copy of the LCD may be helpful.

Suppliers are reminded to monitor use of these items and to discontinue billing if the beneficiary stops using the item. In the event of a claim review, evidence of continued use may be requested. This information may come from the supplier-created records.

Refer to the LCD, related Policy Article and Supplier Manual for additional information on coverage and documentation.

Demand Letters to Medicare Providers and Suppliers Associated with an Item or Service Provided to Incarcerated Beneficiaries

Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated that the beneficiary was incarcerated on the date of service (DOS). Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. Medicare has identified previously paid claims that contain DOS that partially or fully overlap a period when the beneficiary was incarcerated based on information from the Social Security Administration (SSA). A large number of overpayments have been identified and demand letters released with appeals instructions. At this time, CMS asks that providers do not file appeal requests. This issue will be resolved more quickly and efficiently if providers follow the instructions below.

There may be instances where providers believe that the beneficiary was not incarcerated when the service was provided. However, a beneficiary may be "incarcerated" even when the individual is not confined within a penal facility. For example, a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation may, nevertheless, be in the custody of authorities under a penal statute. In such cases, Medicare payment may be barred. Providers receiving demand letters for denial of claims because the beneficiary's SSA record indicates incarceration on the DOS, and who have reason to believe that the beneficiary was not incarcerated on the DOS, may wish to contact the beneficiary to gather as much information as possible.

Information Gathered Indicates SSA Record May Need to be Updated

If a beneficiary did not inform the SSA of his or her release from custody, this may result in his or her record being incorrect. If a provider believes this is the case, the provider may wish to encourage the beneficiary to contact his or her local SSA office in order to have his or her records updated.

It can take up to one month for the beneficiary's Medicare eligibility file to be updated with the revised SSA information. If the beneficiary tells the provider that SSA is updating his or her records, we suggest the provider contact the Medicare Administrative Contractor using the contact information on the overpayment demand letter.

Information Gathered Indicates SSA Record is Current

If the provider believes that the beneficiary was not incarcerated on the DOS in question and the beneficiary advises that SSA's records are currently accurate, the provider can contact their local CMS Regional Office by fax found at: http://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html

At a minimum, providers should be prepared to submit the following information to the appropriate CMS Regional Office:

- Fax Subject: Incarcerated Beneficiary Claim Issue
- Provider Name and Contact information
- Beneficiary Name
- Health Insurance Claim Number
- Dates of Service
- Claim Number (ICN/DCN):
- Reason why incarceration information for the DOS is incorrect

Source: LEARNRESOURCE-L Email Update, National Institutes of Health, U.S. Department of Health and Human Services dated July 15, 2012

FAQs About Incarcerated Beneficiary Claims Denials Now Available

CMS has posted Frequently Asked Questions (FAQs) about incarcerated beneficiary claims denials on the All Fee-For-Service Providers website. These FAQs will be updated as more information becomes available.

INCARCERATED BENEFICIARIES

Update on Medicare Demand Letters and Medicare Claim Cancellations Associated with Item or Service Provided to Incarcerated Beneficiaries

Recently, the Centers for Medicare & Medicaid Services (CMS) initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service. Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. A beneficiary may be "incarcerated" even when the individual is not confined within a penal facility, such as a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation.

Medicare identified previously paid claims that contain a date of service partially or fully overlapping a period when a beneficiary was apparently incarcerated based on information CMS receives from the Social Security Administration (SSA). As a result, a large number of overpayments were identified, demand letters released, and, in many cases, automatic recoupment of overpayments made. CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.

CMS is actively reviewing these data and will be taking action to improve the process used to identify periods of incarceration. As part of this effort, CMS is working to quickly identify claims that resulted in our recent recovery actions and take steps, as appropriate, to correct any inappropriate overpayment recoveries.

CMS will continue to issue messages about this topic, including timeframes for resolution, to keep the provider and supplier community informed. Information will also be posted on the All-Fee-For-Service-Providers page on the CMS website.

In the interim, providers and suppliers should no longer encourage beneficiaries to contact their local Social Security office in order to have their records updated as a result of this recent issue. Providers also should no longer fax information to their local CMS Regional Offices as CMS is currently working to develop processes to resolve this issue.

LCD AND POLICY ARTICLE REVISIONS

External Infusion Pumps LCD – Revised

The External Infusion Pumps LCD refill requirements have been revised to 3-month interval to be consistent with the previously published instructions in the August 2012 article, "Items Provided on a Recurring Basis and Request for Refill Requirements – Revised - August 2012". For complete information, review the entire LCD and/or related Policy Article.

LCD and Policy Article Revisions

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

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

LCD AND POLICY ARTICLE REVISIONS

Date	Policy	Revisions
May 23, 2013	Respiratory Assist Devices (RAD)	Revision Effective Date: 06/01/2013 (May 2013 Publication) COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Added: "or equal to" under Central Sleep Apnea (CSA) criterion 1 Removed: Refill paragraph which has been superseded by CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6 (Clerical correction)
May 23, 2013	Therapeutic Shoes for Persons with Diabetes	Revision Effective Date: 02/04/2011 (May 2013 Publication) HCPCS CODES AND MODIFIERS: Added: GA and GZ modifier DOCUMENTATION REQUIREMENTS: Revised: KX, GA, GY or GZ modifier instruction
June 27, 2013	Oxygen and Oxygen Equipment	LCD Revision Effective Date: 08/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Clarified general recertification issues Added: Refill allowance and bundling instructions Removed: Refill monitoring requirements DOCUMENTATION REQUIREMENTS: Removed: Refill documentation requirements
June 27, 2013	Oral Anticancer Drugs	Revision Effective Date: 06/01/2013 CODING INFORMATION: Added: ICD-9 diagnoses for most recent National Comprehensive Cancer Network (NCCN) updates: 152.0-152.2, 152.8, 152.9, 158.9, 187.1-187.4, 187.8, 187.9, 189.0, 189.1, 199.0, 199.1, 251.1, 251.4, 251.8, V10.52 for capecitabine; 158.9, 238.77, V23.89 for cyclophosphamide; 198.4, 235.2, 235.5, 238.77, V10.00 for etoposide; 204.80, 204.82 for Fludarabine Phosphate; 199.0, 199.1, V10.79 for melphalan; 187.9, 196.0, 198.89 for methotrexate; 157.0, 157.2, 157.9, 179, 180.0, 182.0, 182.1, 182.8, 202.10, 202.18, 202.20, 202.28, 209.21, 235.5, 251.1, 251.4, 251.8, V16.49 for temozolomide; 158.9, 198.4 for Topotecan
July 5, 2013	Glucose Monitors	LCD Revision Effective Date: 08/01/2013 DOCUMENTATION REQUIREMENTS: Revised: Elements of detailed written order for items provided on periodic basis Revised: Continued use requirement for usual utilization vs high utilization POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: High utilization requirements
July 5, 2013	Hospital Beds and Accessories	Revision Effective Date: 08/01/2013 COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: From criterion 3, the requirement of "Pillows or wedges must have been considered and ruled out"
July 5, 2013	Surgical Dressings	Revision Effective Date: 06/01/2013 CODING GUIDELINES: Added: Reference to PDAC coding verification requirement for A6021, A6022, A6023 and A6024

Attestation Statements Must Accompany ADMC, PAR and PMD Claims for Medical Review

Noridian Medicare DME would like to take the opportunity to remind suppliers that an attestation statement is required for a licensed/certified medical professional (LCMP) evaluation to be considered as part of the face-to-face examination for a power mobility device. To fulfill this requirement the attestation must be signed and dated and submitted with all Power Mobility Device (PMD) claims, Prior Authorization Requests (PAR), and Advanced Determination of Medical Coverage's (ADMC) submissions.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier. (**Note:** Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the physician.)

Additional resources include the National Coverage Determination (NCD) 280.3, Local Coverage Determinations (LCDs) L23598, L11462, L15670 and Policy Articles (PA) A41127, A19846, A17265 and CMS Publication 100-8, Program Integrity Manual Chapter 3. https://www.noridianmedicare.com/dme/coverage/resources/power_mobility_devices.html.

Suppliers are encouraged to call the Supplier Contact Center with any questions 1-877-320-0390 between the hours 8 a.m. – 6 p.m. CT.

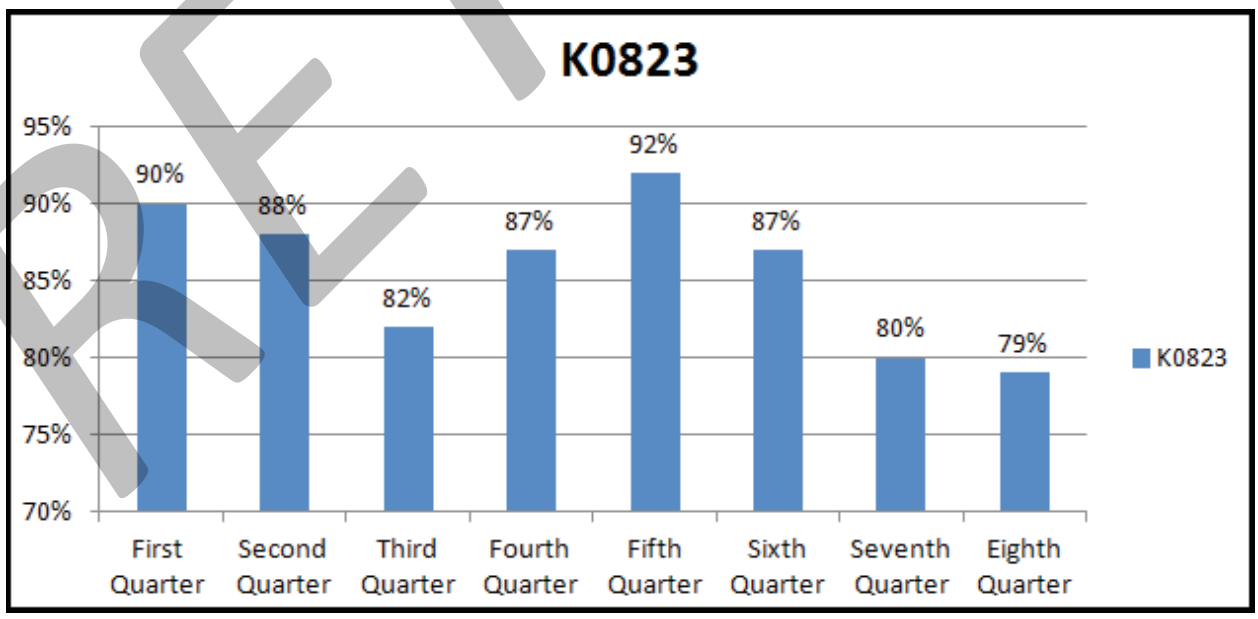
Eighth Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0823 and All Related Accessories)

Current Review Results

The Jurisdiction D, DME MAC, Medical Review Department is conducting a widespread complex review of HCPCS code K0823 and all related accessories. The eighth quarter edit effectiveness results from April 6th, 2013 through July 5th, 2013 are as follows:

The K0823 review involved 361 claims, of which 284 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.

Historical Data of the Error Rate for K0823



Primary Documentation Errors that Resulted in Denial of Claims

- 29.95 % of K0823 claims received a denial as the beneficiary does not have sufficient upper extremity function to self- propel an optimally configured manual wheelchair

The beneficiary's medical records do not support criterion C.

C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform mobility related activities of daily living (MRADL) during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories
- 10.41% of K0823 claims received a denial as the beneficiary's mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker

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

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

- 9.38% of K0823 claims received a denial as there was no detailed product description or the detailed product description submitted was invalid

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

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

- 9.0% of K0823 claims received a denial as the face- to- face examination was incomplete or missing elements

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

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

- Physical examination that is relevant to mobility needs:
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination:
    - Arm and leg strength and range of motion
  - Neurological examination:
    - Gait
    - Balance and coordination

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

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

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

Going Forward

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

Education Resources

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

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

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

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

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

Current Review Results

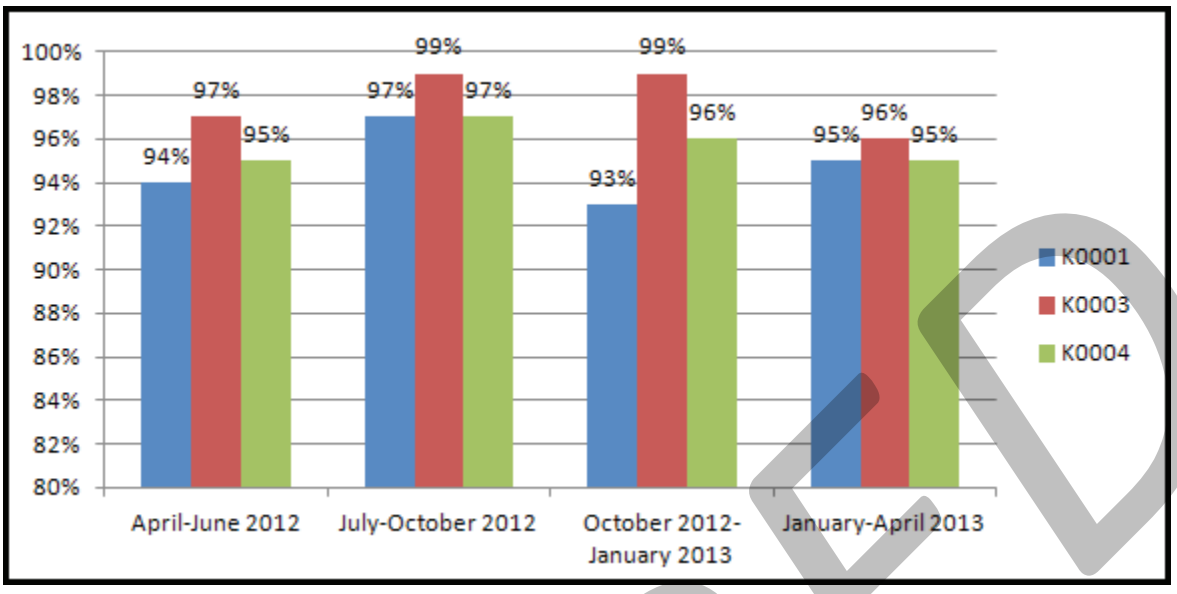
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003 and K0004. The fifth quarter edit effectiveness results from January 2013 through April 2013 are as follows:

The K0001 review involved 960 claims of which 905 were denied. This resulted in an overall error rate of 95%.

The K0003 review involved 538 claims of which 515 were denied. This resulted in an overall error rate of 96%.

The K0004 review involved 477 claims of which 447 were denied. This resulted in an overall error rate of 95%.

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



Primary Documentation Errors that Resulted in Denial of Claims

- 18% of K0001 claims received a denial as criterion B was not met
- 15% of K0003 claims received a denial as criterion B was not met
- 14% of K0004 claims received a denial as criterion B was not met

Medical records provided must support that the beneficiary has a mobility limitation that cannot be sufficiently resolved by the use of an appropriated fitted cane or walker.

- 17% of K0003 claims received a denial as medical records do not support the beneficiary meets the criteria (a) and (b) for a lightweight wheelchair
- 15% of K0004 claims received a denial as criteria (1) or (2) not met for the high strength light weight wheelchair (K0004)

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

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

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

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

- 14% of K0001 claims received a denial as criterion A was not met
- 12% of K0003 claims received a denial as criterion A was not met
- 12% of K0004 claims received a denial as criterion A was not met

Documentation provided must support that 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

- 14% of K0003 claims received a denial as criterion C was not met
- 11% of K0004 claims received a denial as criterion C was not met
- 9% of K0001 claims received a denial as criterion C was not met

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

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

- 17% of K0004 claims received a denial as the requested documentation was not received
- 10% of K0001 claims received a denial as the requested documentation was not received

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

Going Forward

Based on high error rate, Noridian 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 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.

Mobility Assistive Equipment Ask the Contractor Teleconference Q&A – June 13, 2013

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

Email Listserv

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

Provider Enrollment, Chain and Ownership System (PECOS) Update

Noridian would like to remind suppliers of the upcoming PECOS editing. In the future, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

K0009 Change Effective June 1, 2013

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

Face-to-Face and Detailed Written Order (DWO) Requirements

CMS released MLN Matters article 8304 "Detailed Written Orders and Face-to-Face Encounters." The article outlines the changes to the Detailed Written Order and new Face-to-Face requirements for certain DME items. Suppliers are encouraged to review the article as well as the list of affected DME.

Questions Asked Prior to ACT

Q: We are receiving a number of repair calls from beneficiaries who received equipment from another supplier (i.e. scooter, manual & power chairs). How do we make sure our repair services will be covered? When we were not the original provider of services, we need documentation from that provider in order to file a repair claim with Medicare showing that the equipment coverage criteria was met and paid by Medicare. We have had instances where another supplier's paperwork is available and at other times it is not.

A: If a beneficiary needs repairs to equipment and the supplier did not originally dispense the equipment, the repair provider is at risk of losing the Medicare reimbursement for the repair. Suppliers should obtain documentation that the equipment originally met Medicare medical necessity. Examples of obtaining this documentation might be gathering the documentation from the original supplier or the medical records from the ordering practitioner.

Q: With audits and overpayments made to suppliers, how do we service beneficiaries in need and still get paid for our repairs to equipment we did not originally dispense? If Medicare paid for the item originally and now finds there was improper payment, what are the options for both providers & beneficiaries?

A: If the original supplier is still in business, beneficiaries are encouraged to work with the original supplier to obtain necessary services.

Questions Asked During ACT

Q: As follow-up to a pre-submitted question, how are we as the provider of repairs, supposed to get that information?

A: It is important to look to the treating physician in order to obtain those records. It is important to get the documentation on the medical necessity, the condition of the beneficiary and why the chair was needed originally.

Q: How will the new face-to-face requirements affect mobility items as of July 1st?

A: Per Change Request (CR) 8304, there is a listing of items included in which there has to be documentation of a face-to-face examination with either a physician, a physician assistant (PA), a nurse practitioner (NP) or a clinical nurse specialist (CNS), with the beneficiary in the six months prior to the written order for those specified DME items. This does not apply to the power mobility devices because these items have separate face-to-face requirements. Please keep in mind that if a physician assistant, a nurse practitioner or a clinical nurse specialist orders DME items referenced in CR 8304, a physician must document that occurrence of that face-to-face encounter by signing or cosigning and dating that portion of the medical record.

Q: We have gotten some requests for a K0005 wheelchair. Looking at the LCD, many of these patients would qualify for the K0004 but because of long distance it may be better to provide the K0005. Would the K0005 be considered for coverage in these situations?

A: The medical necessity for any type of wheelchair is base on the use within the home.

Follow-up Questions

Q:Would the beneficiary be able to pay for an upgrade to a K0005?

A: Yes, this could be billed as an upgrade situation.

Q: When a supplier provides repair to items that another supplier has initially provided, is it necessary to re-establish the medical necessity for the base item? Would billing non-assigned be of benefit to the supplier providing repair? Suppliers have heard that billing non-assigned can make them "safe" from audit.
A: Regardless of whether a claim is billed assigned or non-assigned by a non-participating supplier, medical necessity must be established for the item provided and that would extend to repair as well. It is the supplier's responsibility to evaluate the medical necessity and to determine whether the coverage criteria for that item have been met. It would not be appropriate to look at this issue in terms of being "safe" from audit, as it is always the responsibility of the supplier who submits a claim to Medicare with expectation of Medicare payment – whether to the supplier or the beneficiary – to determine that the item either meets medical necessity, or the beneficiary has been informed of the specific reason that medical necessity is not met and provided an opportunity to elect service by completing an ABN.

Q: Is there a timeframe for the doctor to cosign the PA, NP or CNS' face-to-face notes?
A: Enforcement of CR 8304 has been delayed and additional information will be coming.

Q: My understanding is the face-to-face examination cannot be done by a physical therapist. Is that correct?
A: Yes, their evaluation can be used in the medical records to help with documentation. However the examination needs to be done by the physician, PA, NP or CNS. The new rule is saying if the PA, NP or CNS does the face-to-face examination, then the physician has to sign off on it for items addressed in CR 8304.

Q: For the detailed written order, is the physician required to sign off on that for billing purposes?
A: The detailed written order can be signed by the PA, NP or the CNS. There is no requirement to have a physician sign off on the order.

Q: When a beneficiary is being discharged from the hospital or a skilled healthcare facility, does the person taking the verbal order have to be an employee of the physician?
A: No. The employee of the supplier taking the order must be identified.

Q: Is there an effective date for when the PECOS editing will start denying claims?
A: Currently there is no date for when this editing will start. Once CMS provides this information, it will be posted to our website.

Results of Widespread Prepayment Targeted Review of Power Mobility Devices (HCPCS K0824)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment targeted review of HCPCS code K0824. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) review analysis.

The K0824 review involved 34 claims of which 26 were denied. This resulted in an overall error rate of 82%.

Primary Documentation Errors that Resulted in Denial of Claims

- 23.08% of K0824 claims received a denial as the documentation did not support that an optimally-configured manual wheelchair was insufficient

The beneficiary's medical records do not support criterion C.

Criterion C: The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform mobility related activities of daily living (MRADL) during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories
- 15.38% of K0824 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.

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.

- 9.23% of K0824 claims received a denial as the documentation did not support that a cane or walker was insufficient

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

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

- 9.23% of K0824 claims received a denial as there was no detailed product description or the detailed product description submitted was invalid

LCD L23598 states, "Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-08) Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the power wheelchair (PWC) or power operated vehicle (POV). A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be availableon request.

Going Forward

Noridian will close this widespread targeted review.

Education Resources

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

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

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

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

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

Current Review Results

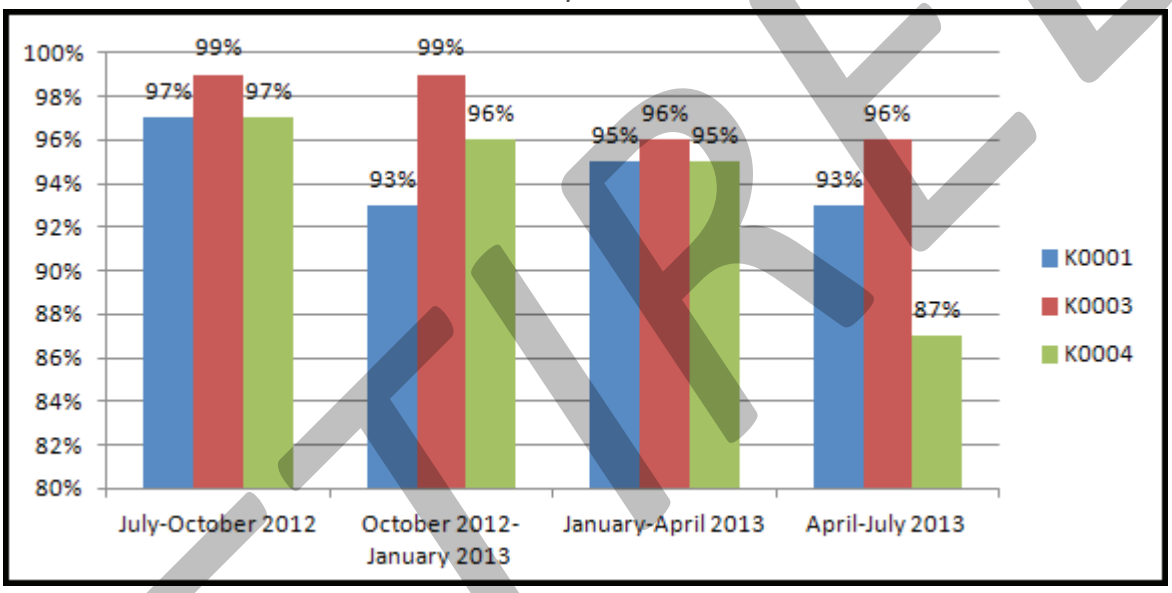
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003 and K0004. The fifth quarter edit effectiveness results from April 2013 through July 2013 are as follows:

The K0001 review involved 951 claims of which 899 were denied. This resulted in an overall error rate of 93%.

The K0003 review involved 633 claims of which 614 were denied. This resulted in an overall error rate of 96%.

The K0004 review involved 372 claims of which 344 were denied. This resulted in an overall error rate of 87%.

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



Primary Documentation Errors that Resulted in Denial of Claims

- 18% of K0001 claims received a denial as criterion B was not met
- 15% of K0003 claims received a denial as criterion B was not met
- 14% of K0004 claims received a denial as criterion B was not met

Medical records provided must support that the beneficiary has a mobility limitation that cannot be sufficiently resolved by the use of an appropriated fitted can or walker

- 19% of K0003 claims received a denial as medical records do not support the beneficiary meets the criteria (a) and (b) for a lightweight wheelchair
- 18% of K0004 claims received a denial as criteria (1) or (2) not met for the high strength light weight wheelchair (K0004)

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

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

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

1. The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair

2. The beneficiary requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair

- 13% of K0001 claims received a denial as criterion A was not met
- 10% of K0003 claims received a denial as criterion A was not met
- 10% of K0004 claims received a denial as criterion A was not met

Documentation provided must support that 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:

Prevents the beneficiary from accomplishing an MRADL entirely, or

Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

Prevents the beneficiary from completing an MRADL within a reasonable time frame.

- 16% of K0001 claims received a denial as criterion C was not met
- 12% of K0003 claims received a denial as criterion C was not met

Documentation must support that 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.

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

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

- 11% of K0001 claims received a denial as criterion F was not met

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

Going Forward

Based on high error rate, Noridian 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.htm.

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.

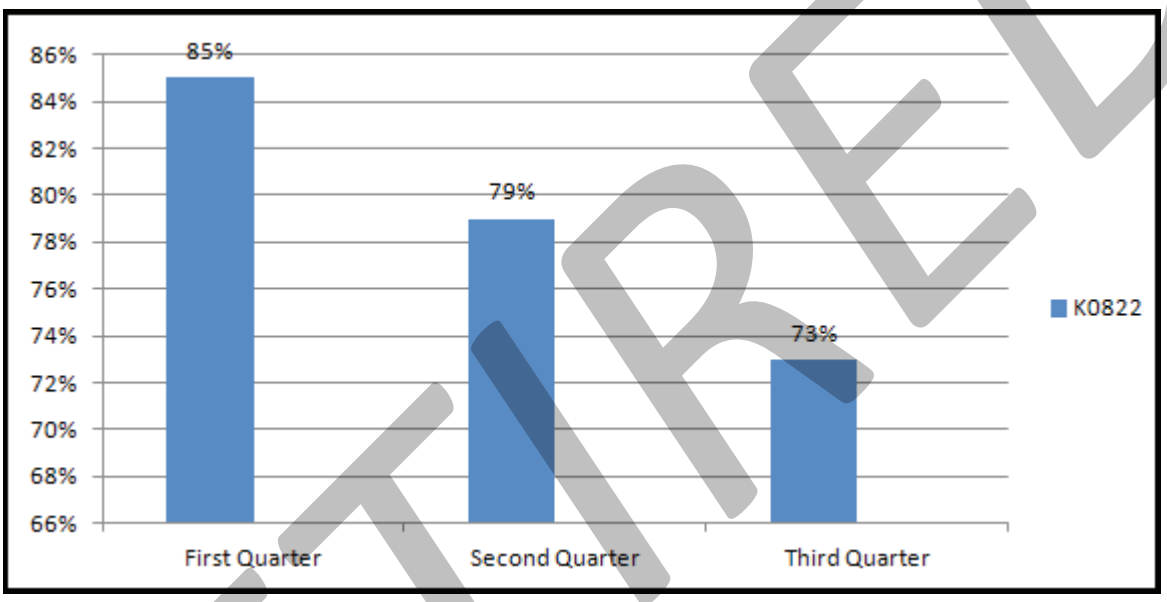
Third Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0822)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code K0822. The third quarter edit effectiveness results from January 2013 to April 2013 are as follows:

The K0822 review involved 77 claims of which 55 were denied. This resulted in an overall error rate of 73%.

Historical Data of the Error Rate for K0822 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 20.66% of K0822 claims received a denial as the documentation did not support that an optimally-configured manual wheelchair was insufficient

The beneficiary's medical records do not support criterion C.

The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform mobility related activities of daily living (MRADL) during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories
- 15.70% of K0822 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.

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.

- 11.57% of K0822 claims received a denial as there was no detailed product description or the detailed product description submitted was invalid

LCD L23598 states, "Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-08) Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.

The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the power wheelchair (PWC) or power operated vehicle (POV). A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be availableon request.

- 9.09% of K0822 claims received a denial as the documentation did not support that a cane or walker was insufficient

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

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

Going Forward

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

Education Resources

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

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

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

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

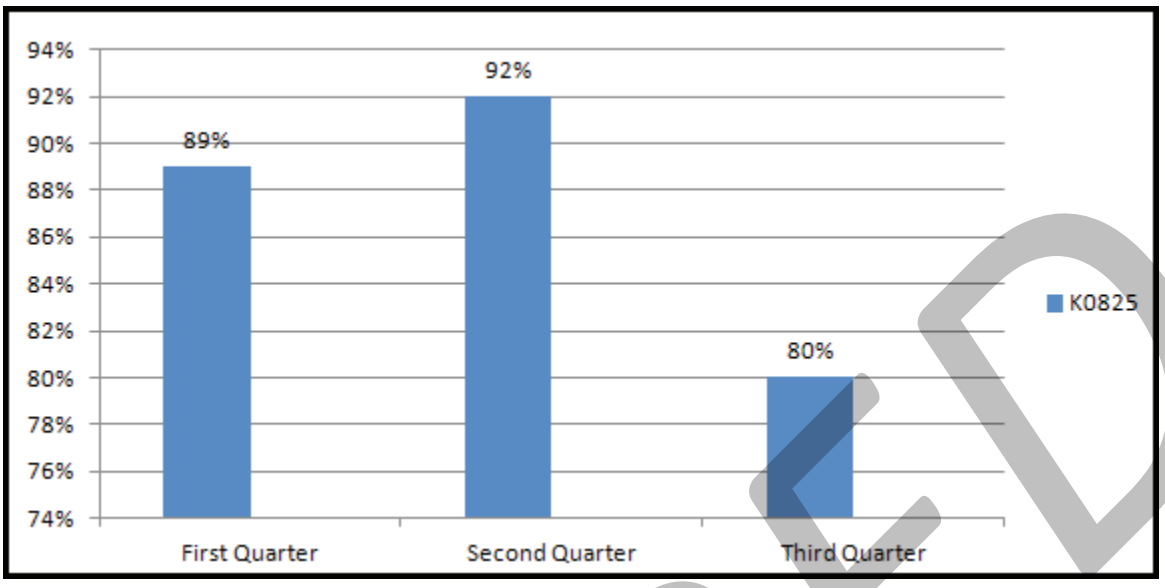
Third Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0825)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code K0825. The third quarter edit effectiveness results from January 2013 to April 2013 are as follows:

The K0825 review involved 122 claims of which 93 were denied. This resulted in an overall error rate of 80%.

Historical Data of the Error Rate for K0825 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 31.48% of K0825 claims received a denial as the documentation did not support that an optimally-configured manual wheelchair was insufficient

The beneficiary's medical records do not support criterion C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform mobility related activities of daily living (MRADL) during a typical day

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories
- 12.50% of K0825 claims received a denial as the documentation did not support that a cane or walker was insufficient

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

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

- 10.65% of K0825 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.

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.

- 8.33% of K0825 claims received a denial as the documentation did not support that a power operated vehicle was insufficient

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

The beneficiary is able to:

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

Going Forward

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

Education Resources

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

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

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

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

Overutilization of Nebulizer Medications

MLN Matters® Number: SE1326

Provider Types Affected

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

Provider Action Needed

Durable Medical Equipment suppliers who submit claims for inhalation drugs need to know the maximum units per month that may be billed to meet medical necessity guidelines. A table of the maximum units per month for inhalation drugs to meet medical necessity is published in Local Coverage Determinations (LCDs) for Nebulizers, which are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the Centers for Medicare & Medicaid Services (CMS) website. Once at that site, enter the key word "nebulizers" where requested and select the appropriate choice for your Geographic Area/Region to view the applicable LCD. Claims billed for units that exceed the allowable amounts will be considered an overpayment. Make sure that your billing staffs are aware of these maximum billing amounts for inhalation drugs.

Background

This article is based on the results of an automated review of claims for inhalation drugs by the Recovery Auditors. The auditors reviewed claims with the following J codes:

- J2545 (PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG);
- J7605 (ARFORMOTEROL, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 15 MICROGRAMS);

- J7606 (FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS);
- J7608 (ACETYLCYSTEINE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM);
- J7611 (ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG);
- J7612 (LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG);
- J7620 (ALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 0.5 MG, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME);
- J7626 (BUDESONIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG);
- J7631 (CROMOLYN SODIUM, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS);
- J7639 (DORNASE ALFA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM);
- J7644 (IPRATROPIUM BROMIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM); and
- J7669 (METAPROTERENOL SULFATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS)

As previously noted, a table of the maximum units per month for inhalation drugs to meet medical necessity is published in LCDs for Nebulizers. Claims billed for units that exceed the allowable amounts will be considered an overpayment.

Here are two examples of excess billings:

- A 66 year-old male was dispensed 360 units of J7620 (Albuterol/Ipratropium Combination) on May 21, 2012. The same patient was then dispensed another 360 units of J7620 on June 11, 2012, and another 360 units of J7620 on July 2, 2012. In total, the patient received 1080 units of J7620 in three months. Per the LCDs for nebulizers, patients are allowed 186 units of J7620 per one month refill period. Based on the number of units dispensed in June and July 2012, the excess units dispensed in May were not for use in the following two months. Therefore, 174 units of J7620 dispensed May 21, 2012 are overpaid. At the time of this service the policy in effect allowed for delivery of refills no sooner than 10 days prior to the end of usage for the current product.
- A 60 year-old female was dispensed 1200 units of J7611 (Albuterol) on February 14, 2012. The same patient was dispensed 1200 units of J7611 on March 19, 2012, and an additional 1200 units on April 20, 2012. In total, the patient received 3600 units of J7611 in three months. Per the LCDs for nebulizers, patients are allowed 465 units of J7611 per one month refill period. Based on the number of units dispensed in March and April 2012, the excess units dispensed in February were not for use in the following two months. Therefore, 735 units of J7611 dispensed February 14, 2012 are overpaid. At the time of this service, the policy in effect allowed for delivery of refills no sooner than 10 days prior to the end of usage for the current product.

How You Can Improve Your Billing

You are encouraged to review the following documents in the LCD section of the Medicare Coverage Database:

- "NEBULIZERs," addresses coverage indications, limitations, and medical necessity, accessories, inhalation drugs and solutions, including a table representing the maximum milligrams/month of inhalation drugs that are reasonable and necessary for each nebulizer drug, and refill requirements. Please find this document, updated March, 15, 2013, posted by your DME MAC (use ID of L5007, L27226, L11499, or L11488), available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website.

- "NEBULIZERs" - Policy Article - Effective April 2013. Search for the article posted by your DME MAC (use ID of A24623, A47233, A24944, A24944, or 24942), available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website. This document addresses coding information and general information about documentation requirements, prescription requirements and medical record information, in addition to coverage indications, limitations, and medical necessity, accessories, inhalation drugs and solutions, including a table representing the maximum milligrams/month of inhalation drugs that are reasonable and necessary for each nebulizer drug, and refill requirements.

The "Medicare National Coverage Determinations Manual," Chapter 1, Part 4, Coverage Determinations, Section 280.1 has a Durable Medical Equipment Reference List, and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf on the CMS website.

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code J7605 and J7626. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from April 1, 2013 through June 30, 2013, resulted in an overall error rate of 35%.

Primary Documentation Errors that Resulted in Denial of Claims

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

There were no medical records submitted to support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9).
Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

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

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items.

Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

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

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

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

For non-consumable supplies, i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies) - the supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

The order submitted was invalid.

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

- Physician signature and signature date
- For items provided on a periodic basis, including drugs, the written order must include
- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

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

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

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

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

The DWO must be available upon request.

Going Forward

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

Education Resources

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

Nebulizers

- Local Coverage Determination L11488
- Policy Article A24942
- In addition, the following references are educational resources related to the HCPCS code being reviewed:
- Documentation Checklists: https://www.noridianmedicare.com/dme/coverage/docs/checklists/nebulizers_and_respiratory_drugs.html
- Physician Resource Letters: https://www.noridianmedicare.com/dme/coverage/resources.html.

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

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

Appropriate Coding and Billing of Lower Limb Prosthetic Covers and Covering Systems

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received a high volume of submitted claims for lower limb prosthetic covers (L5704–L5707) and protective covering systems (L5962, L5964, and L5966) for the same lower limb prosthesis. The need for both of these is rare, and this article is intended to educate suppliers and providers about the occasions where both of these are considered to be reasonable and necessary.

Lower limb prosthetic covers (L5704–L5707) are complete products and afford shape, protection and waterproofing for normal daily usage of the prosthesis. They offer sufficient protection and weatherproofing for patients who require lower limb prosthetics.

Protective outer surface covering systems (L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of that which is afforded by L5704–L5707. They are not covered for cosmetic or convenience reasons, or for everyday usage in a typical environment. This type of product is separate from the covering that is already reimbursed as part of L5704–L5707 and is rarely necessary.

Documentation to support medical necessity of a protective outer surface covering system (L5962, L5964, and L5966) must indicate the type of extraordinary activities that would justify the need for extra protection afforded by this highly durable item. Again, this type of extra protection is not routinely necessary.

When billing for the protective outer surface covering systems (L5962, L5964 and L5966), information regarding the type of protective cover provided (i.e., manufacturer name, make, model or type) must be included on claims in order to ensure correct coding.

Suppliers should utilize the Medicare Pricing, Data Analysis and Coding Contractor (PDAC) website to ensure accurate coding of DMEPOS claims.

Billing Reminder – AFO/KAFO Prefabricated Base Orthoses and Custom-Fabricated Additions

Recently errors in billing for combinations of custom–fabricated orthotic additions with prefabricated base orthoses have been identified.

The Coding Guideline sections of the policy article for Ankle-Foot/Knee-Ankle-Foot Orthoses and Knee Orthoses define prefabricated and custom-fabricated as follows:

> A prefabricated orthosis is one, which is manufactured in quantity without a specific beneficiary in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.
>
> A custom-fabricated orthosis is one, which is individually made for a specific beneficiary starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

It is inherent in the definition of prefabricated that a particular item is complete. Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and will be denied as not reasonable and necessary if billed with prefabricated base orthotics.

Refer to the LCD for Ankle-Foot/Knee-Ankle-Foot Orthoses and Knee Orthoses for additional information about coverage, documentation and billing for these items.

First Quarter Results of Widespread Prepayment Review of Claims for Spinal Orthoses LSO (HCPCS L0631 and L0637)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L0631 and L0637. The first quarter edit effectiveness results from December 2012 through March 2013 are as follows:

The L0631 review involved 327 claims of which 268 were denied. This resulted in an overall error rate of 83%.

The L0637 review involved 175 claims of which 143 were denied. This resulted in an overall error rate of 82%.

Primary Documentation Errors that Resulted in Denial of Claims

- 32% of L0631 claims received a denial as coverage criteria (1–4) as indicated in Spinal Orthoses LCD (L11459) were not met
- 52% of L0637 claims received a denial as coverage criteria (1–4) as indicated in Spinal Orthoses LCD (L11459) were not met

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

1. To reduce pain by restricting mobility of the trunk; 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

- 12% of L0631 claims received a denial as no documentation was received in response to the additional documentation request
- 14% of L0637 claims received a denial as no documentation was received in response to the additional documentation request

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

- 10% of L0631 claims received a denial as the proof of delivery provided was invalid
- 8% of L0631 claims received a denial as no proof of delivery was provided
- 14% of L0637 claims received a denial as no proof of delivery was provided

Proof of Delivery (PIM 4.26, 5.8)

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

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

Method 1–Direct Delivery to the Beneficiary by the Supplier

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

- Beneficiary's name
- Delivery address

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

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

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

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

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

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

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

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

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

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

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

- 9.6% of L0637 claims received a denial as no detailed written order or dispensing order was received.

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

Dispensing Orders (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders (PIM 5.2.3)

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

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

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

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

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

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

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

The DWO must be available upon request.

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

Going Forward

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

Education Resources

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

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

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

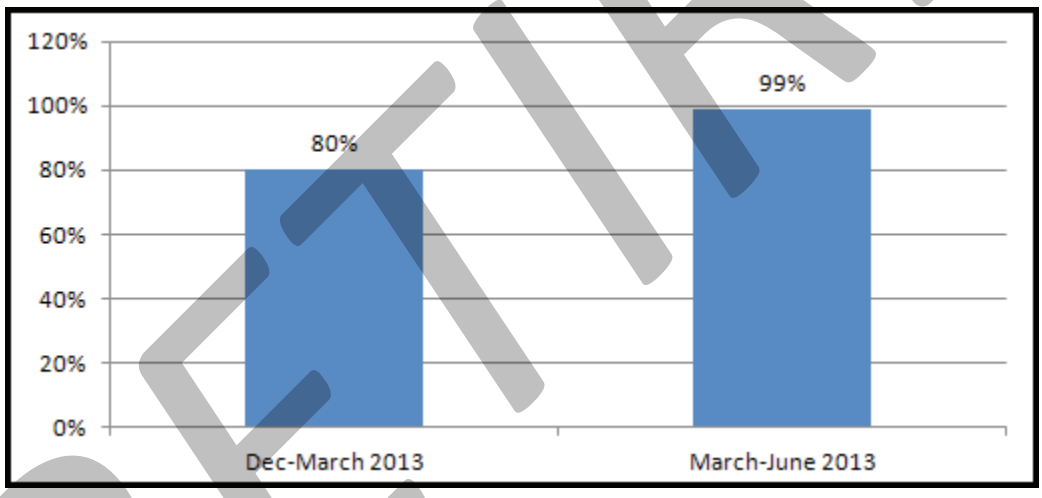
Second Quarter Results of Widespread Prepayment Review of Claims for Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1960)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code L1960. The second quarter edit effectiveness results from March 2013 through June 2013 are as follows:

The L1960 review involved 225 claims of which 221 were denied. This resulted in an overall error rate of 99%.

Historical Data of the Error Rate for L1960 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 27% of L1960 claims received a denial as the treating physician's records don't provide detailed documentation to support medical necessity of custom rather than prefabricated orthosis

For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support the medical necessity of custom-fabricated rather than a prefab orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

- 21% of L1960 claims received a denial as criteria 1–5 were not met

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

1. The beneficiary could not be fit with a prefabricated AFO; or,
2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration more than 6 months); or,

3. There is a need to control the knee, ankle or foot in more than one plane; or,
4. The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
5. The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions

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

- 16% of L1960 claims received a denial as the documentation was insufficient to support basic coverage criteria

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

- 7% of L1960 claims received a denial as no documentation was provided to support the reason for replacing the item

Replacement of a complete orthosis or component of an orthosis due to loss, significant change in the beneficiary's condition, or irreparable accidental damage is covered if the device is still reasonable and necessary. The reason for the replacement must be documented in the supplier's record.

Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are denied as not reasonable.

Going Forward

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

Education Resources

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

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

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

Second Quarter Results of Widespread Prepayment Review of Claims for Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1970 and L4360)

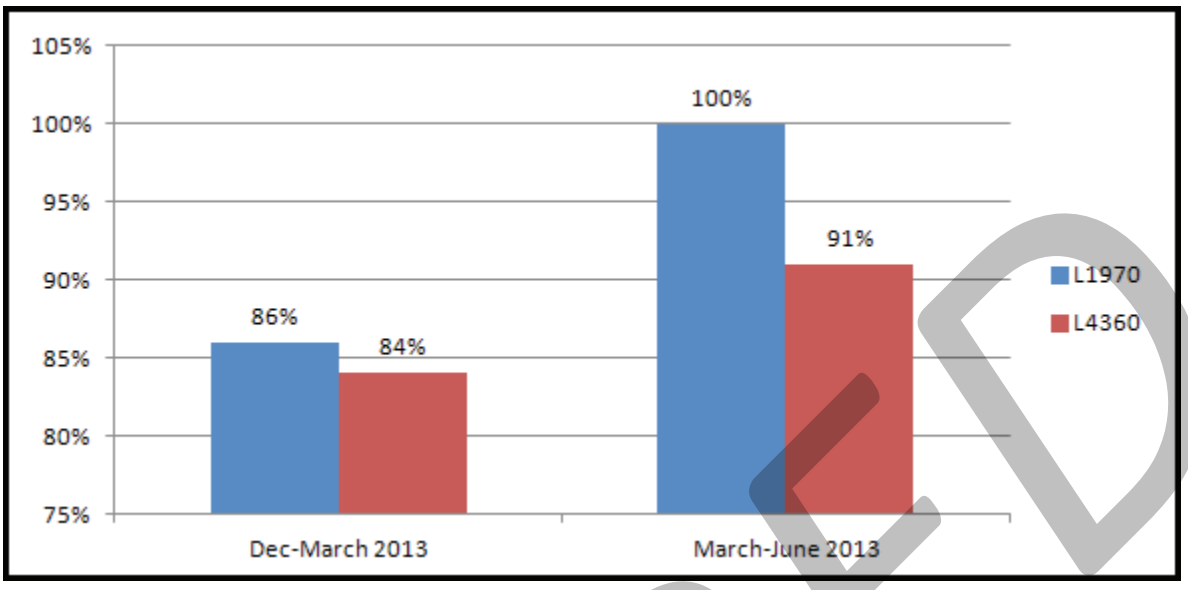
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L1970 and L4360. The second quarter edit effectiveness results from March 2013 through June 2013 are as follows:

The L1970 review involved 20 claims of which 20 were denied. This resulted in an overall error rate of 100%.

The L4360 review involved 1,170 claims of which 1,063 were denied. This resulted in an overall error rate of 91%.

Historical Data of the Error Rate for L1970 and L4360 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 19% of L4360 claims received a denial as the documentation was insufficient to support basic coverage criteria
- 12% of L1970 claims received a denial as the documentation was insufficient to support basic coverage criteria

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

- 19% of L4360 claims received a denial as no proof of delivery was submitted
- 18% of L4360 claims received a denial as no detailed written order or dispensing order was provided

No proof of delivery was submitted.

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

No detailed written order or dispensing order was provided.

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

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

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

- Beneficiary's name
- Physician's name
- Date of the order and start date, if start date different than date of order
- Detailed description of the item(s)
- Physician signature and signature date
- 14% of L1970 claims received a denial as criteria 1-5 not met

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

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

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

- 14% of L1970 claims received a denial as the treating physician's records don't provide detailed documentation to support medical necessity of custom rather than prefabricated orthosis

For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support the medical necessity of custom-fabricated rather than a prefab orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

Going Forward

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

Education Resources

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

Suppliers can also review specific policy resources for Ankle-Foot/Ankle-Knee-Foot orthosis on the Noridian website at https://www.noridianmedicare.com/dme/train/education_tools.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

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

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

Second Quarter Results of Widespread Prepayment Review of Claims for Spinal Orthoses: LSO (HCPCS L0631 and L0637)

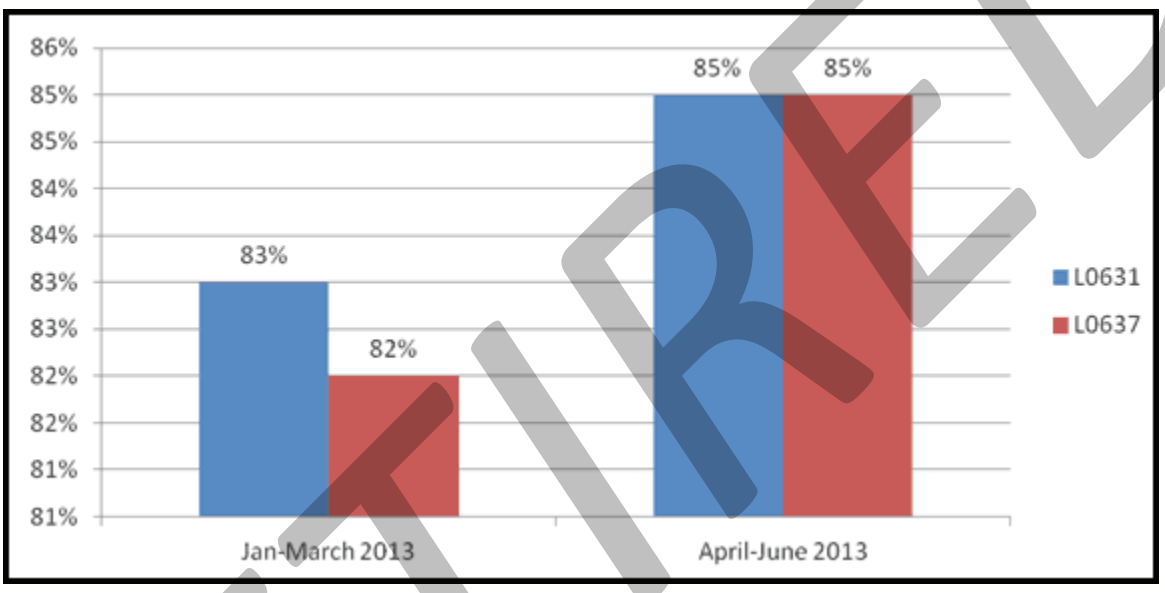
Current Review Results

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

The L0631 review involved 947 claims of which 803 were denied. This resulted in an overall error rate of 85%.

The L0637 review involved 397 claims of which 335 were denied. This resulted in an overall error rate of 85%.

Historical Data of the Error Rate for L0631 and L0637 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 33% of L0631 claims received a denial as coverage criteria (1–4) as indicated in Spinal Orthoses LCD (L11459) were not met
- 24% of L0637 claims received a denial as coverage criteria (1–4) as indicated in Spinal Orthoses LCD (L11459) were not met

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

1. To reduce pain by restricting mobility of the trunk; 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

- 22% of L0631 claims received a denial as no documentation was received in response to the additional documentation request
- 26% of L0637 claims received a denial as no documentation was received in response to the additional documentation request

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

- 9% of L0631 claims received a denial as the proof of delivery provided was invalid
- 11% of L0637 claims received a denial as no proof of delivery was provided

PROOF OF DELIVERY (PIM 4.26, 5.8)

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

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

Method 1–Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

- 8% of L0631 claims received a denial as no office notes/medical records were provided
- 8% of L0637 claims received a denial as no office notes/medical records were provided

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

Going Forward

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

Education Resources

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

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

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

OSTEOGENESIS STIMULATORS

Results of Widespread Prepayment Probe Review of Osteogenesis Stimulators (HCPCS E0747 and E0748)

Review Results

Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes E0747 and E0748. This review was initiated based on high Comprehensive Error Rate Testing (CERT) review analysis.

The E0747 review involved 95 claims of which 77 were denied. This resulted in an overall error rate of 81%.

The E0748 review involved 100 claims of which 49 were denied. This resulted in an overall error rate of 49%.

Primary Documentation Errors that Resulted in Denial of Claims for E0747

- 51% of E0747 claims received a denial as documentation requirements were not met for 2 sets of x-rays separated by minimum of 90 days
- 16% of E0747 claims received a denial as they did not meet criteria for nonunion of a long bone fracture or failed fusion of a joint other than in the spine where a minimum of 9 months has elapsed since the last surgery
- 4% of E0747 claims received a denial due to having an incomplete or invalid CMN

OSTEOGENESIS STIMULATORS

Nonunion of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogensis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

The 1st set of radiographs must have been obtained after surgery/setting/repair of the fracture, followed by a second set submitted a minimum of 90 days later.

LCD 11490 is specific as to diagnosis coded and listing of what qualifies as a long bone fracture. A long bone is limited to a clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal.

Bunion/hammer toes surgery does not qualify or surgery for failed hardware.

Primary Documentation Errors that Resulted in Denial of Claims for E0748

- 49% of E0748 claims received a denial as the spinal surgery was not a 3 level spinal fusion
- 5 % of E0748 claims received a denial as they contained invalid proof of delivery (POD)

LCD 11490 defines a multilevel spinal fusion as one which involves 3 or more vertebrae (e.g. L3-L5, L4-S1, etc.). Two separate spinal fusions of 2 vertebrae will be denied.

Going Forward

Noridian will close this probe review on HCPCS codes E0747 and E0748.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Osteogenesis Stimulator Local Coverage Determination (LCD) L11490 and Policy Article A35423.

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

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

OXYGEN

Coverage Reminder – High Liter-Flow Oxygen (>4 LPM)

Recent reviews of high liter-flow oxygen claims have identified errors in billing for high liter-flow and portable oxygen systems. This article will review basic coverage and documentation requirements.

Oxygen and oxygen equipment is eligible for payment for beneficiaries who have a qualifying medical condition that results in hypoxemia (low blood oxygen levels). A stationary oxygen system is the equipment covered when a beneficiary qualifies. Additional payment is available for a portable system if it is necessary to move about inside the beneficiary's home.

There are three payment levels for oxygen based upon the liter-flow prescribed:

- Less than 1 lpm – pays less than the standard payment amount
- 1–4 lpm – is the standard payment amount
- Greater than 4 lpm – pays more than the standard payment amount

In order to qualify for the highest payment level, greater than 4 lpm, a second blood oxygen test must be obtained while the beneficiary is breathing oxygen at 4 lpm. A qualifying test result must be obtained while at that liter-flow in order to justify payment at the higher rate. If the beneficiary qualifies for payment at the higher rate, there is no additional payment for a portable oxygen system. The **indications and limitations of coverage and/or medical necessity** section of the LCD says:

Liter flow greater than 4 LPM:

- If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the beneficiary is on 4 or more LPM meets Group I or II criteria. If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. (Refer to related Policy Article for additional information on payment for greater than 4 LPM oxygen.) (emphasis added)

The **nonmedical necessity coverage and payment rules** section of the related Policy Article says:

Payment for stationary equipment is increased for beneficiaries requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for beneficiaries requiring less than 1 LPM. If a beneficiary qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, payment will be made for the stationary system at the higher allowance, but not for the portable system. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied as not separately payable (emphasis added).

Modifiers QF and QG must be used when submitting the claim.

- QF – Prescribed amount of oxygen is greater than 4 liters per minute (LPM) and portable oxygen is prescribed
- QG – Prescribed amount of oxygen is greater than 4 liters per minute (LPM)

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

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

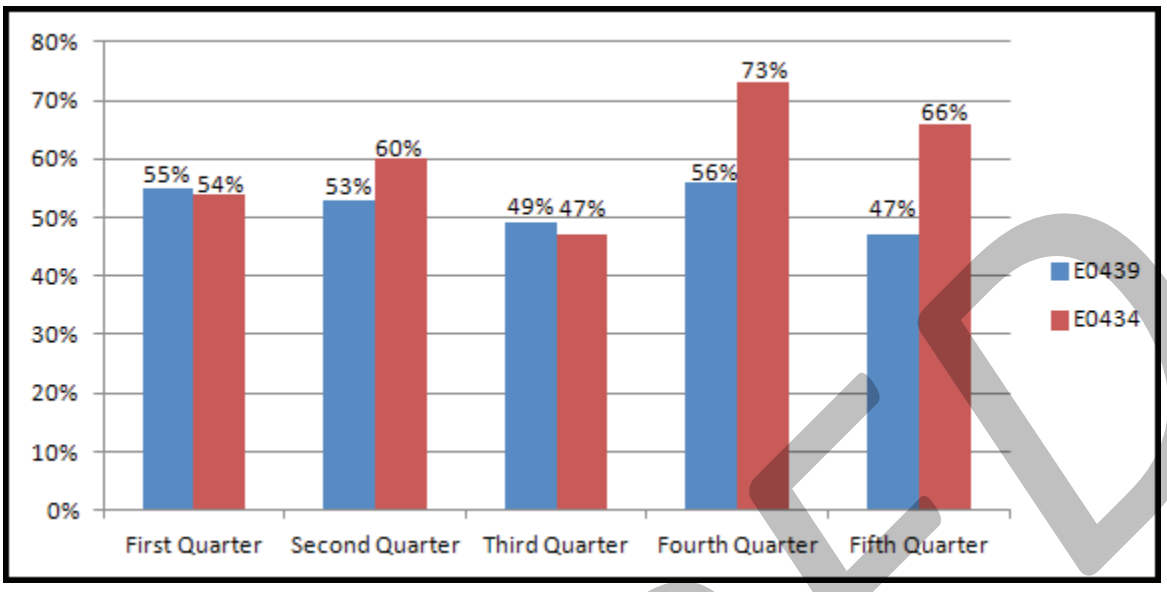
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0439 and E0434. The fifth quarter edit effectiveness results from April 5, 2013 through July 4, 2013 are as follows:

The E0439 review involved 344 claims of which 172 were denied. This resulted in an overall error rate of 47%.

The E0434 review involved 165 claims of which 97 were denied. This resulted in an overall error rate of 66%.

Historical Data of the Error Rate for E0439 and E0434 Review



Primary Documentation Errors that Resulted in Denial of Claims

- There is no detailed written/dispensing order received or the order was incomplete/missing elements

The supplier for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is required to keep on file a physician prescription (order). A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary. The treating physician must sign and date the detailed written order.

Dispensing Orders

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.2

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

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

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

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

The dispensing order must be available upon request.

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

Detailed Written Orders

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.3

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

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

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

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

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

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

The DWO must be available upon request.

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

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

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

- The date of signature on the detailed written order is after the date of service (DOS) with no verbal/dispensing order provided

Dispensing Orders

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.2

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

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

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

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.The dispensing order must be available upon request.

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

Detailed Written Orders

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.3

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

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

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

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

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

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

The DWO must be available upon request.

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

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

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

- There is no DIF/CMN received or the CMN is incomplete or invalid

A Certificate of Medical Necessity (CMN) or a DME Information Form (DIF) is a form required to help document the medical necessity and other coverage criteria for selected durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. CMNs contain sections A through D. Sections and C are completed by the supplier and Sections B and D are completed by the physician. A DIF is completed and signed by the supplier. It does not require the cost, a narrative description of equipment or a physician's signature.

For certain items or services billed to a DME MAC, the supplier must receive a signed CMN from the treating physician or a signed DIF from the supplier. A supplier must have a faxed, photocopied, original signed order, or an electronic CMN or DIF in their records before they can submit a claim for payment to Medicare. CMNs or DIFs have a DME MAC form number, e.g., 01, 02, 03 and a revision number, e.g., .01, .02. Some forms also have an alpha suffix, e.g., A, B, C.

A completed CMN or DIF must be maintained by the supplier and be available to the DME MAC on request. When hardcopy CMNs or DIFs are submitted to the DME MAC, the supplier must include a copy of only the front side. When CMNs are submitted electronically, information from sections A and B are required.

Noridian provides fillable CMNs and DIFs, in which data can be entered and printed. These interactive forms can be found in the Forms section, CMNs and DIFs category, on the Noridian DME website.

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

The "Signature Date" is the date the physician signed and dated Section D of the CMN. This date might not be the same as the "Initial Date", since the "Signature Date" must indicate when the physician signed Section D of the CMN. Medicare requires a legible identifier for services provided/ordered. The method used, e.g., hand written or electronic, to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. Rather, an indication of a signature in some form needs to be present.

If there is a change made to any section of the CMN after the physician has signed the CMN, the physician must either line through the error, initial, and date the correction or the supplier may choose to have the physician complete a new CMN.

For items that require a CMN, the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed. If the item requires a written order prior to delivery and the supplier uses the CMN as the written order, the supplier must have received the fully completed CMN (original "pen and ink," electronically maintained, photocopy, or facsimile mage) before dispensing the item. For accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed.

- There is no proof of delivery (POD) submitted or the POD is invalid

Proof of Delivery

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

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

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

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

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

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

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

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

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

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

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

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

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

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

Going Forward

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

Education Resources

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

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

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

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

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

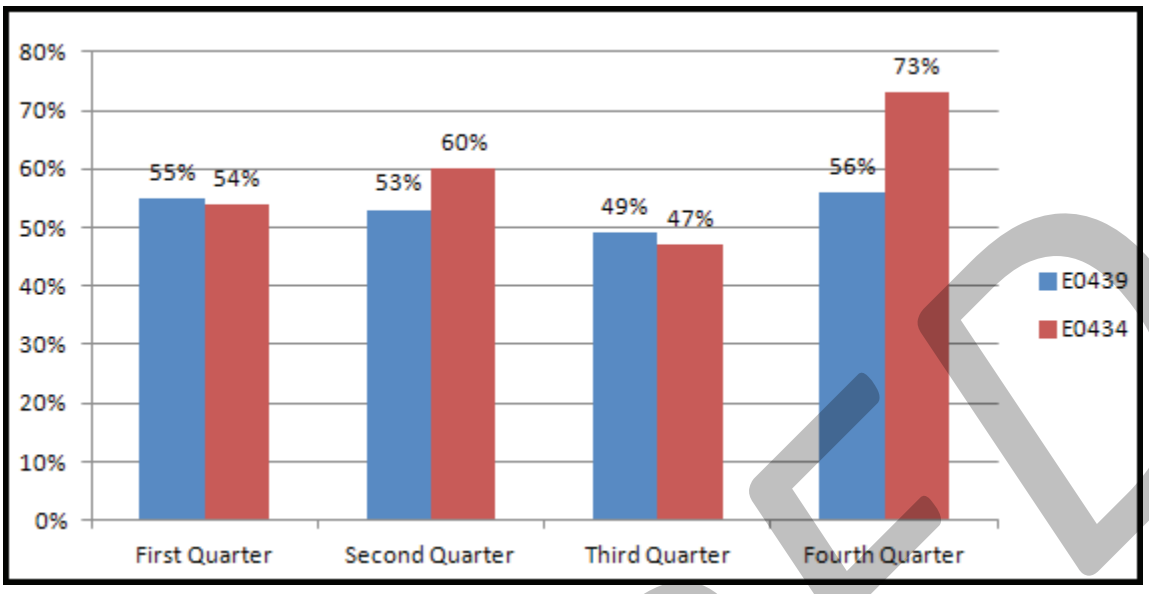
Current Review Results

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

The E0439 review involved 275 claims of which 151 were denied. This resulted in an overall error rate of 56%.

The E0434 review involved 175 claims of which 119 were denied. This resulted in an overall error rate of 73%.

Historical Data of the Error Rate for E0439 and E0434 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 14% of E0439 claims received a denial as no documentation was received
- 16% 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.

- 13% 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
- 12% 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).
- 12% 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
- 10% 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

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:

- 9% of E0439 claims received a denial as the proof of delivery received was dated prior to the date of service on the claim
- 11% of E0434 claims received a denial as the proof of delivery received was dated prior to the date of service on the claim

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.

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.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the 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.

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

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code E1390, oxygen concentrator. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from March 2013 through May 2013, resulted in an overall error rate of 46%.

Primary Documentation Errors that Resulted in Denial of Claims

There was no documentation to support the beneficiary had been seen and evaluated by the treating physician within 30 days prior to the date of the initial Certificate of Medical Necessity (CMN).
LCD L11457 Testing and Visit Requirements:

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

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

Requested documentation was not received by the contractor within the allotted timeframe. Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

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

The documentation provided did not contain the beneficiary's most recent arterial blood gas P02 and/or oxygen saturation test.

- LCD L11457 indicates the qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. These prohibitions do not extend to blood gas studies performed by a hospital certified to do such tests.
- The qualifying blood gas study may be performed while the beneficiary is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria
- When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test done at rest and awake is nonqualifying, but either an exercise or sleep oximetry test on the same day is qualifying, the exercise or oximetry test result will determine coverage.
- All oxygen qualification testing must be performed in-person by a physician or other medical professional qualified to conduct oximetry testing. With the exception of overnight oximetry (see below), unsupervised or remotely supervised home testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment.
- Claims for oxygen equipment and supplies for beneficiaries who do not meet the coverage requirements for home oxygen therapy will be denied as not reasonable and necessary

A dispensing order for the equipment billed was not provided.

Dispensing Orders (PIM 5.2.2)
Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

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

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

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

The dispensing order must be available upon request.

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

Going Forward

Based on the results of this review, Noridian will continue with the E1390 Documentation Compliance Review.

Education Resources

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

- Oxygen and Oxygen Equipment:
  - Local Coverage Determination L11457
  - Policy Article A33677
  - National Coverage Determination 240.2

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

- Documentation Checklists
- Physician Resource Letters
- CMN Form
- Policy Specific Training/Events

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

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

Third Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment billed with the RA modifier (HCPCS E0439 and E0434)

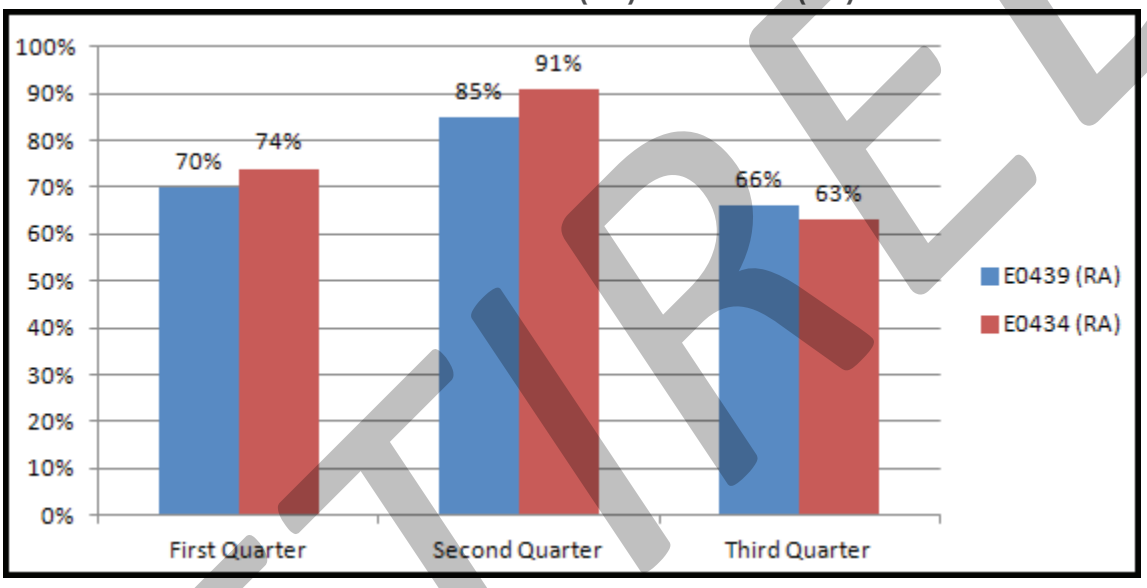
Current Review Results

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 third quarter edit effectiveness results from December 2012 to March 2013 are as follows:

The E0439 (RA) review involved 18 claims of which 12 were denied. This resulted in an overall error rate of 66%.

The E0434 (RA) review involved 46 claims of which 30 were denied. This resulted in an overall error rate of 63%.

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



Primary Documentation Errors that Resulted in Denial of Claims

- 52% of E0439 (RA) claims received a denial as no documentation was received
- 21% 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.

- 21% of E0439 (RA) claims received a denial as the date of the signature on the written order or certificate of medical necessity (CMN) is signed after the date of service with no dispensing order received
- 21% of E0434 (RA) claims received a denial as the date of the signature on the written order or certificate of medical necessity (CMN) is signed after the date of service with no dispensing order received

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.3

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.

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.

For items that require a CMN, the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed. If the item requires a written order prior to delivery and the supplier uses the CMN as the written order, the supplier must have received the fully completed CMN (original "pen and ink," electronically maintained, photocopy, or facsimile mage) before dispensing the item.

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

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

- 10% of E0439 (RA) claims received a denial as no documentation was provided to support continued use
- 14% 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.

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.

- 10% of E0439 (RA) claims received a denial as no documentation was submitted to support continued need
- 10% 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 will continue with the Prepayment Widespread Review.

Education Resources

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

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

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

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

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

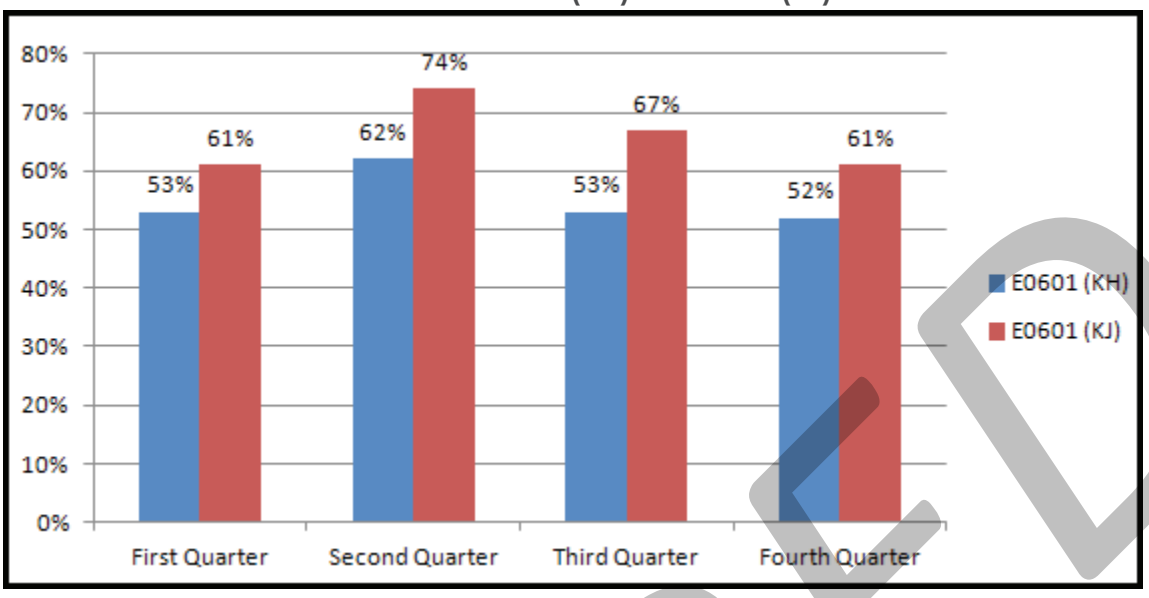
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0601 for the first month of billing (KH modifier) and the 4th-13th month of billing (KJ modifier). The fourth quarter edit effectiveness results from January 2013 to April 2013 are as follows:

The E0601 (KH) review involved 3176 claims of which 1669 were denied. This resulted in an overall error rate of 52%.

The E0601 (KJ) review involved 938 claims of which 557 were denied. This resulted in an overall error rate of 61%.

Historical Data of the Error Rate for E0601 (KH) and E0601 (KJ) Review



Primary Documentation Errors that Resulted in Denial of Claims

- 17% of E0601 (KH) claims received a denial as no documentation was received
- 13% of E0601 (KJ) claims received a denial as no documentation was received

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

- 15% of E0601 (KH) claims received a denial as criterion A was not met
- 10% of E0601 (KJ) claims received a denial as criterion A was not met

The patient must have a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea. (Criteria A of LCD L171)

- 8% of E0601 (KH) 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.

- 17% of E0601 (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:

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

Going Forward

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

PAP DEVICES

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 LCD : Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L171) (LCD) L171 and ARTICLE : Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea – Policy Article – Effective February 2011 (A19827) A19827.

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

Noridian 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.

PRESSURE REDUCING SUPPORT SURFACES

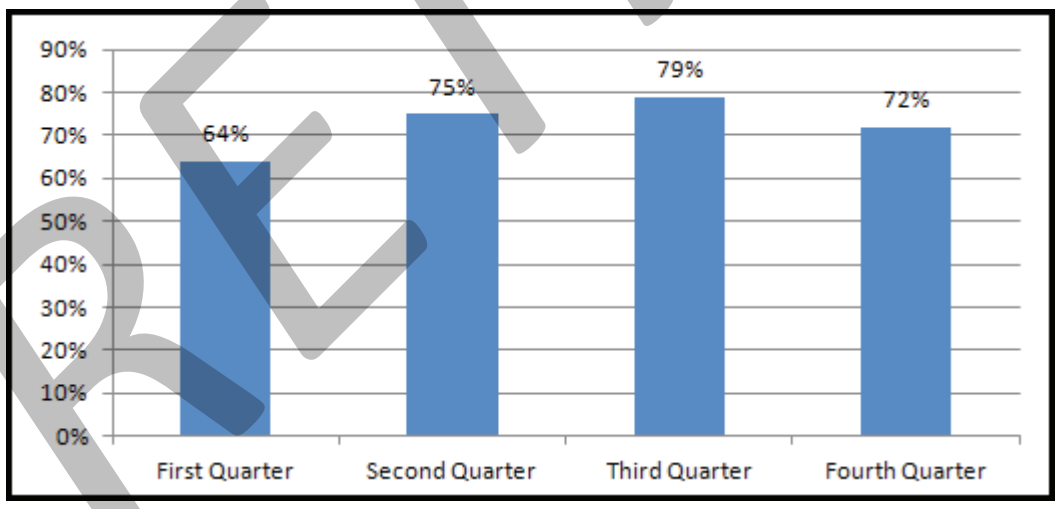
Fourth Quarter Results of Widespread Prepayment Review of Claims for Group 2 Pressure Reducing Support Surfaces (HCPCS E0277)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0277. The fourth quarter edit effectiveness results from February 2013 through April 2013 are as follows:

The E0277 review involved 220 claims of which 151 were denied. This resulted in an overall error rate of 72%.

Historical Data of the Error Rate for E0277 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 21% of E0277 claims received a denial as Criterion 1 (previously Criteria 1, 2 and 3) not met
- 20% of E0277 claims received a denial as Criterion 2 (previously Criterion 4) not met
- 19% of E0277 claims received a denial as Criterion 3 (previously Criteria 5 & 6) not met

1. A group 2 support surface is covered if the beneficiary meets at least one of the following three Criteria (1, 2 or 3)
2. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02–707.05) which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following
    i. Use of an appropriate group 1 support surface, and
    ii. Regular assessment by a nurse, physician, or other licensed healthcare practitioner, and
    iii. Appropriate turning and positioning, and
    iv. Appropriate wound care, and
    v. Appropriate management of moisture/incontinence, and
    vi. Nutritional assessment and intervention consistent with the overall plan of care
3. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02–707.05)
4. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (ICD-9 707.02–707.05), and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days
    i. 10% of E0277 claims received a denial as no documentation was received

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

Going Forward

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

Education Resources

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

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

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

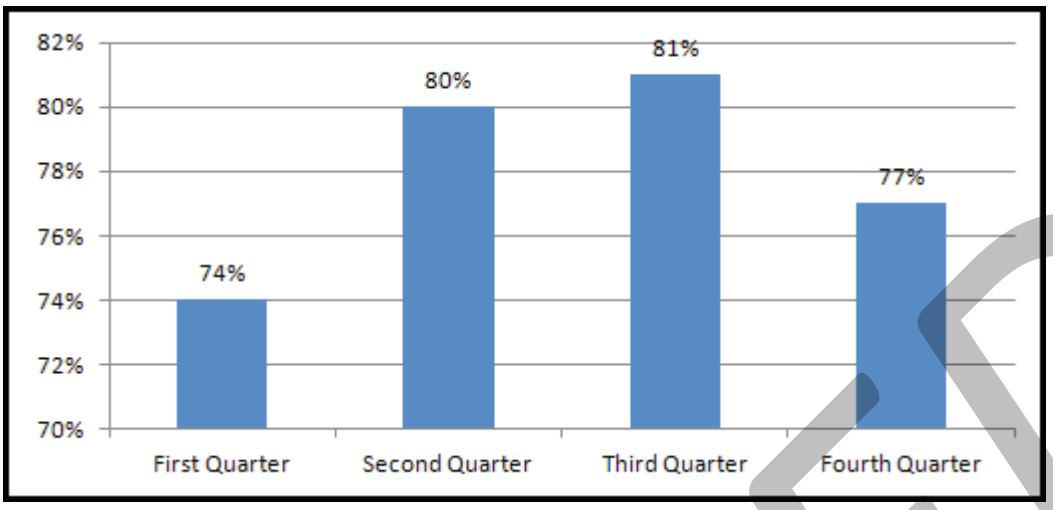
Fourth Quarter Results of Widespread Prepayment Review of Claims for Group 1 Pressure Reducing Support Surfaces (HCPCS E0181)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0181. The fourth quarter edit effectiveness results from January 2013 through April 2013 are as follows:

The E0181 review involved 339 claims of which 264 were denied. This resulted in an overall error rate of 77%.

Historical Data of the Error Rate for E0181 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 30% of E0181 claims received a denial as no documentation was received

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

- 15% of E0181 claims received a denial as Criteria 1, 2 or 3 were 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 – 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
- 14% of E0181 claims received a denial as no office notes or medical records were provided

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

- 10% of E0181 claims received a denial as Criteria A–D not met for Criteria 2 & 3

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

Going Forward

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

Education Resources

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

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

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

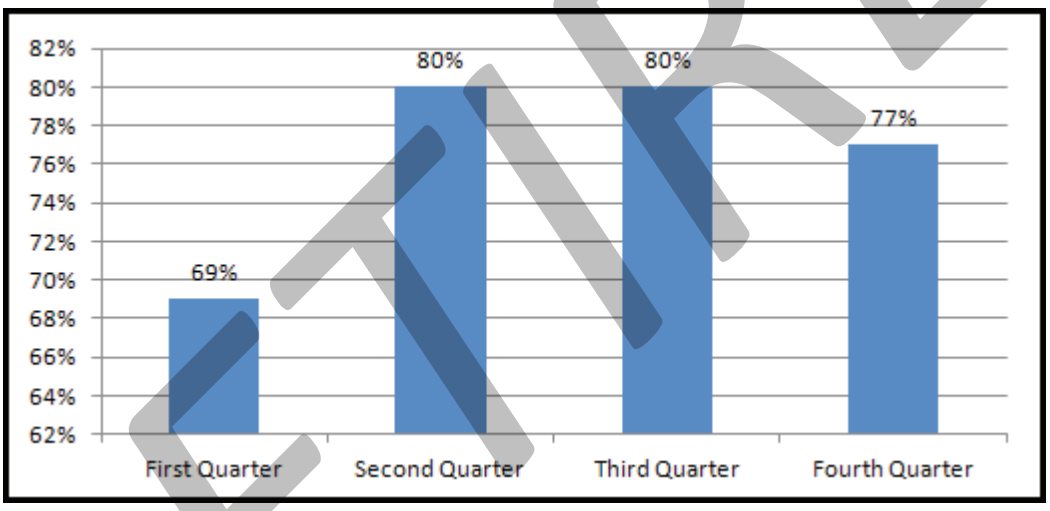
Fourth Quarter Results of Widespread Prepayment Review of Claims for Group 1 Pressure Reducing Support Surfaces (HCPCS E0185)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E0185. The fourth quarter edit effectiveness results from February 2013 through April 2013 are as follows:

The E0185 review involved 500 claims of which 386 were denied. This resulted in an overall error rate of 77%.

Historical Data of the Error Rate for E0185 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 29% of E0185 claims received a denial as Criteria 1, 2 or 3 not met

A group 1 mattress overlay or mattress is covered if one of the following three criteria are met

1. The patient is completely immobile – i.e., patient cannot make changes in body position without assistance, or
2. The patient has limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A–D below, or
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A–D

- 19% of E0185 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.

- 11% of E0185 claims received a denial as Criteria A–D not met for Criteria 2 & 3

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

- 10% of E0185 claims received a denial as no office notes or medical records were provided

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

Going Forward

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

Education Resources

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

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

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

REFILLS

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

July Quarterly Update for 2013 DMEPOS Fee Schedule

MLN Matters® Number: MM8325 Revised
Related Change Request (CR) #: CR 8325
Related CR Release Date: May 17, 2013
Effective Date: January 1, 2013 - for implementation of fee schedule amounts for codes in effect on January 1, 2013; July 1, 2013 for all other changes
Related CR Transmittal #: R2709CP
Implementation Date: July 1, 2013

Note: This article was revised on August 1, 2013, to add additional language to address questions raised about the implementation of the non-mail order fee schedule changes required by the American Taxpayer Relief Act.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8325 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

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

Key Points of CR8325

- CR 8325 updates fees for Healthcare Common Procedure Coding System (HCPCS) codes E2378, L5859, and L7902. These HCPCS codes were added to the HCPCS file effective January 1, 2013. Previously these items were paid on a local fee schedule. If claims for these codes with dates of service on or after January 1, 2013 have already been processed, they will be adjusted to reflect the new fees if you bring the claims to your contractor's attention.
- As part of this update fee schedule amounts are also established for HCPCS code K0009 (Other Manual Wheelchair/Base). Payment on a fee schedule basis is mandated for all DME by section 1834(a) of the Social Security Act (the Act), other than items that meet the definition of customized DME at 42 CFR section 414.224 of the regulations. Effective July 1, 2013, payment for claims for manual wheelchairs, that receive a HCPCS code verification of K0009 by the Pricing Data Analysis and Coding (PDAC) contractor, will be made on a capped rental basis with the fee schedule amounts established in accordance with section1834 (a)(8) of the Act using data for all manual wheelchair codes effective in 1986.

Diabetic Testing Supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the American Taxpayer Relief Act (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act. The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. This provision of the ATRA achieves competitive non-mail order prices for the same diabetic testing supplies furnished through the national mail order program without requiring local pharmacies to compete and be awarded contracts while still providing Medicare beneficiaries a choice in where they obtain supplies.

Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

- A4233 Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each
- A4234 Replacement Battery, Alkaline, J Cell, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each
- A4235 Replacement Battery, Lithium, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each
- A4236 Replacement Battery, Silver Oxide, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each
- A4253 Blood Glucose Test or Reagent Strips for Home Glucose Monitor, Per 50 Strips
- A4256 Normal, Low and High Calibration Solution / Chips
- A4258 Spring-powered Device for Lancet, Each
- A4259 Lancets, Per Box of 100

Effective for dates of service on or after July 1, 2013, the non-mail order fee schedule amounts for the diabetic testing supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies.

The annual covered item update will not be applied to the new national fee schedule amounts for non-mail order diabetic testing supplies. Rather, the non-mail order fee schedule amounts on the fee schedule file will be updated each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted. The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law. Since claim assignment is not mandatory for diabetic testing supplies furnished on a non-mail order basis, beneficiaries should ask the pharmacy or supplier storefront for the supplier's charge and whether they will accept assignment of the claim before purchase.

The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 are:

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

Effective July 1, 2013, only national mail order contract suppliers will be paid by Medicare for diabetic testing supplies other than those that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront. The single payment amount public use file for the national mail order competitive bidding program is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet. Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order diabetic testing supplies, the mail order fee schedule amounts (KL modifier) for these codes will remain on the DMEPOS fee schedule file as reference data. The mail order diabetic testing supply fee schedule amounts will be maintained and updated annually by the covered item update for use in establishing bid limits for future competitive bidding competitions.

Additional Information

The official instruction, CR 8325 issued to Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2709CP.pdf on the CMS website.

Phase III Electronic Remittance Advice (ERA) Enrollment Operating Rules

MLN Matters® Number: MM8223 Revised
Related Change Request (CR) #: 8223
Related CR Release Date: May 10, 2013
Related CR Transmittal #: R1235OTN
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Note: This article was revised on May 10, 2013, to reflect a revised CR8223 issued on May 10. In the article, the CR release date, transmittal number, and the Internet address for accessing the CR were revised. All other information remains the same.

Provider Types Affect

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

What You Need to Know

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

Medicare contractors must update their Electronic Remittance Advice (ERA) Enrollment forms for new enrollments:

1. Identify a maximum set of standard data elements to be requested from providers for enrollment to receive Electronic Remittance Advice (ERA). to comply with Attachment 1 of CR 8223. The contractors must comply with the following requirements:
2. Apply "controlled vocabulary" – predefined and authorized terms- for use when referring to the same data element
3. Use standard data elements to appear on paper enrollment form in a standard format and flow, using consistent data elements and vocabulary as on the electronic form
4. Use specific information or instruction to providers to assist in manual paper-based ERA enrollment
5. Offer electronic ERA enrollment

Background

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

What You Need to Know about the ERA Enrollment Form

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

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

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

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

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

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

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

Additional Information

The official instruction, CR 8223, issued to your FI, carrier and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1235OTN.pdf on the CMS website.

Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice

MLN Matters® Number: MM8182 Revised
Related Change Request (CR) #: CR 8182
Related CR Release Date: May 9, 2013
Related CR Transmittal #: R12330TN
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Note: This article was revised on May 10, 2013, to reflect a revised CR8182 issued on May 9. In the article, the CR release date, transmittal number, and the Internet address for accessing the CR were revised. All other information remains the same.

Provider Types Affected

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

What You Need To Know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at http://aspe.hhs.gov/admnsimp/pl104191.htm#1173 on the internet).

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to Electronic Data Interchange (EDI) from paper has been slow and "disappointing" (You can find a copy of this testimony at http://www.ncvhs.hhs.gov/ on the internet).

Note: The same rules will also apply to Standard Paper Remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA Operating Rule Set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule;
2. Phase III CORE 382 ERA Enrollment Data Rule;
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
4. CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT Operating Rules under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT Operating Rules mandate consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule), that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional Information Required - Missing/Invalid/Incomplete Documentation

This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed Service Not Covered by Health Plan

This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for Billed Service Not Separately Payable

This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

Additional Information

The official instruction, CR8182, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1233OTN.pdf on the CMS website You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes
(835) Rule).

Endeavor: Security Awareness Training and Recertification

Endeavor users will be prompted to complete security awareness training and recertify Endeavor accounts.

Security Awareness Training

Existing Endeavor users will be prompted upon login to complete security awareness training. This will occur on a yearly basis in conjunction with the recertification. The process will initiate 45 days prior to the last day of the month in which the users account was initially setup. This training must be completed within the 45 day period in order to continue using Endeavor. If this training is not completed within the timeframe, the user's account will be disabled and the user must contact Endeavor Support in order to unlock it. Upon logging in again, the user will be prompted to complete the training. If the training is not completed within 90 days, the user's account will be deleted and the user must re-register.

New users of Endeavor will be prompted to complete this training upon the first login. The timeframe for new users is the same as existing users.

Recertification

Endeavor users will be prompted to recertify Endeavor accounts on a yearly basis. This recertification demonstrates the Endeavor account is being used by the appropriate person. The process will initiate 45 days prior to the last day of the month in which the users account was initially setup. The recertification must be completed within the 45 day period in order to continue using Endeavor. If the account is not recertified within the timeframe, the user's account will be disabled and the user must contact Endeavor Support in order to unlock it. Upon logging in again, the user will be prompted to recertify the account. If it is not recertified within 90 days, the user's account will be deleted and the user must re-register.

Endeavor Support

- Part A: 1-877-908-8431, User Security
- Part B: 1-877-908-8431, User Security
- DME: dmeendeavor@noridian.com

Endeavor: Unique Identification Number - Revised

Endeavor users will be faxed a Unique Identification Number (UIN) in the near future. The UIN will be a required element when inquiring on an Endeavor account, effective June 24th. The following information must be provided to Noridian Endeavor Support on any Endeavor inquiry:

- User Name
- Company Name
- UIN

Users are strongly encouraged to verify the fax number on the account by following these steps:

1. Log into Endeavor
2. Select either Change Password or Add Provider from the left side of the main menu
3. Select Profile on the left side of the page to open the options and select Edit Profile
4. Verify/change the information and select Save to save the changes

Endeavor Support

- Part A: 1-877-908-8431, User Security
- Part B: 1-877-908-8431, User Security
- DME: dmeendeavor@noridian.com

Endeavor Account Deleted if Noridian Contacted by Unauthorized User

Effective June 10, 2013, Endeavor accounts will be deleted if someone other than the User listed on the registration contacts Noridian regarding the account. This includes password resets, unlock account requests, change of information, etc. Due to security policies, this change is necessary to ensure security is achieved for the user as well as the information within Endeavor. After an account is deleted, the user needs to re-register.

Example #1 - The User on an account is John Doe. Jane Smith contacts Noridian to request a password reset for John's account. Per the requirement listed above, John's account will be deleted and an email will be sent providing the reason for the termination of the account. If Jane Smith needs access to Endeavor, a new user registration must be submitted in her name.

Example #2 - John Doe no longer works at the company and he shared his User id with Jane Smith for her to use. When Jane contacts Noridian to have the password reset, the account will be deleted because Jane is not listed as the User, per the requirement listed above. If Jane Smith needs access to endeavor, a new user registration must be submitted in her name.

If you have any questions regarding this change, please feel free to contact User Security/DME using the contact information below:

- Part A: 877-908-8431, User Security
- Part B: 877-908-8431, User Security
- DME: dmeendeavor@noridian.com

Endeavor Inactive Accounts Disabled and Deleted

Effective May 24, 2013, Endeavor accounts with 60 days of inactivity will be disabled. Users must contact Endeavor Support in order to unlock them. After 90 days of inactivity, Endeavor accounts will be deleted and users must re-register for a new account.

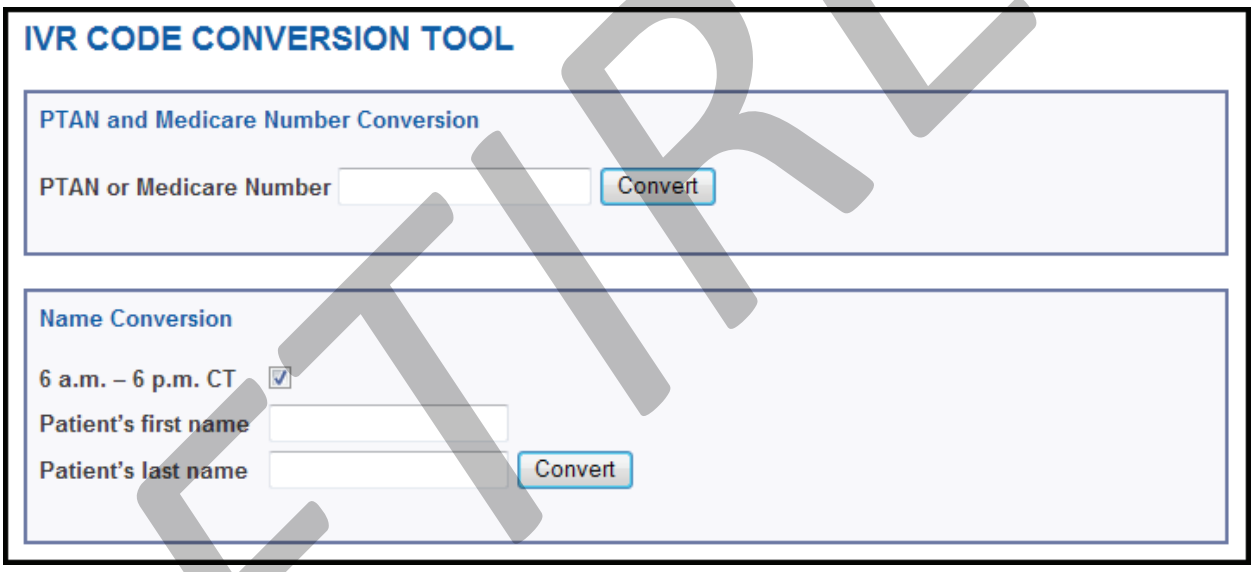
Endeavor Support

- Part A: 1-877-908-8431, User Security
- Part B: 1-877-908-8431, User Security
- DME: dmeendeavor@noridian.com

IVR Conversion Tool Now Available

Noridian now offers providers the Interactive Voice Response (IVR) Code Conversion Tool to assist in using the IVR. Enter the Provider Transaction Access Number (PTAN), National Provider Identifier (NPI), and the beneficiary's first and last name to convert this information into the appropriate sequence of numbers to enter in the IVR.

The Name Conversion section also provides a checkbox for the time to ensure the correct information is entered in the IVR after 6 p.m. CT and prior to 6 a.m. CT.



The IVR Conversion Tool is available on the following home pages under Web Tools:

- Part A: www.noridianmedicare.com/parta
- Part B: www.noridianmedicare.com/partb
- DME: www.noridianmedicare.com/dme

It is also located on the following IVR pages:

- Part A: https://www.noridianmedicare.com/parta/contact/ivr_instructions.html
- Part B: https://www.noridianmedicare.com/partb/contact/ivr_instructions.html
- DME: https://www.noridianmedicare.com/dme/contact/contact.html

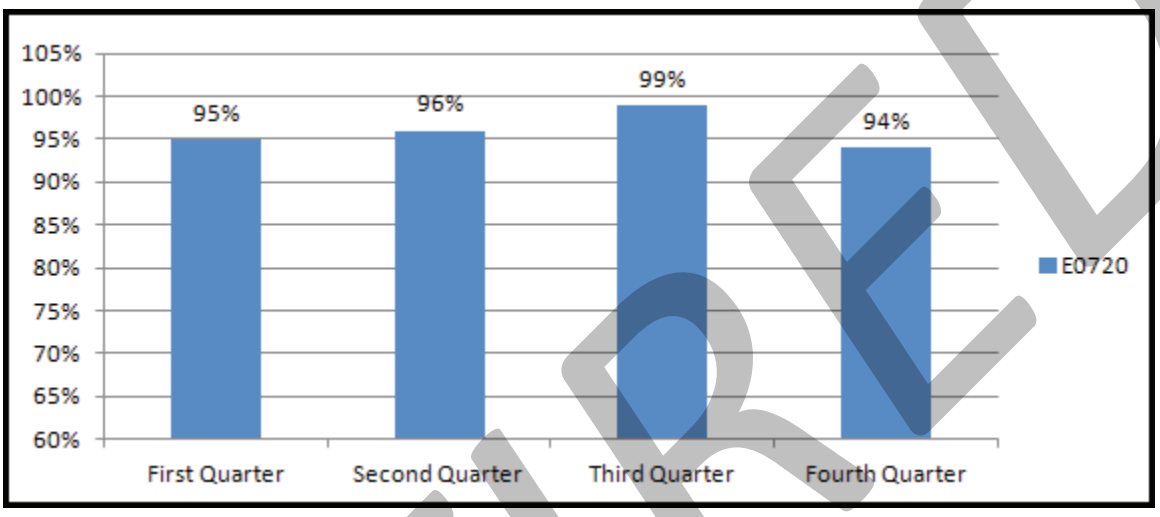
Fourth Quarter Results of Widespread Prepayment Review of Claims for TENS 2-LEAD (HCPCS E0720)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0720. The fourth quarter edit effectiveness results from February 2013 through May 2013 are as follows:

The E0720 review involved 46 claims of which 43 were denied. This resulted in an overall error rate of 94%.

Historical Data of the Error Rate for E0720 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 13% of E0720 claims received a denial as the documentation provided does not support usage and frequency.

Per LCD L11495, For chronic pain covered under criterion II, there must be information in the medical record describing:

- the location of the pain
- the severity of the pain
- the duration of time the beneficiary has had the pain
- the presumed etiology of the pain
- prior treatment and results of that treatment
- re-evaluation of the beneficiary at the end of the trial period, must indicate:
  - how often the beneficiary used the TENS unit
  - the typical duration of use each time
  - the results (effectiveness of therapy)
- 13% of E0720 claims received a denial as the documentation provided does not support pain was present for 3 months

Per LCD L11495, Transcutaneous Electrical Nerve Stimulators (TENS) is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met: The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, temporomandibular joint (TMJ) pain. The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed.

- 11% of E0720 claims received a denial as the documentation provided does not support CLBP criteria

TENS therapy for CLBP is only covered when all of the following criteria are met:

- The beneficiary has one of the following ICD-9 diagnoses:
  - 353.4 Lumbosacral root lesions, not elsewhere classified
  - 720.2 Sacroiliitis, not elsewhere classified
  - 721.3 Lumbosacral spondylosis without myelopathy
  - 721.42 Thoracic or lumbar spondylosis with myelopathy – lumbar region
  - 722.10 Lumbar intervertebral disc without myelopathy
  - 722.52 Lumbosacral intervertebral disc
  - 722.73 Intervertebral disc disorder myelopathy – lumbar region
  - 722.83 Post laminectomy syndrome – lumbar region
  - 722.93 Other and unspecified disc disorders, lumbar region
  - 724.02 Spinal stenosis, lumbar region without neurogenic claudication
  - 724.03 Spinal stenosis, lumbar region with neurogenic claudication
  - 724.2 Lumbago
  - 724.3 Sciatica
  - 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular syndrome of lower extremities
  - 738.4 Acquired spondylolysthesis
  - 739.3 Non-allopathetic lesions NEC (not elsewhere classified) – lumbar region
  - 756.11 Spondylosysis, lumbosacral region
  - 756.12 Spondylolisthesis
  - 805.4 Fracture of vertebral column without mention of spinal cord injury, lumbar, closed
  - 806.4 Fracture of vertebral column with mention of spinal cord injury, lumbar, closed
  - 846.0 Sprains and strains of sacroiliac region – lumbosacral (joint) (ligament)
  - 846.1 Sprains and strains of sacroiliac ligament
  - 847.2 Sprains and strains of other and unspecified parts of back, lumbar
  - 953.2 Injury to nerve roots and spinal plexus, lumbar root
- The beneficiary is enrolled in an approved clinical study that meets all of the requirements set out in NCD §160.27 (CMS Internet Only Manual 100-3, Chapter 1). Refer to the APPENDICES section for additional information about approved clinical studies.

TENS therapy for CLBP that does not meet these criteria will be denied as not reasonable and necessary.

- 10% of E0720 claims received a denial as the documentation provided does not support other appropriate treatment modalities had been tried and failed

Per LCD L11495, other appropriate treatment modalities must have been tried and failed, and the medical record must document prior treatment and results of that treatment.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators Local Coverage Determination (LCD) L11495 and Policy Article A37074.

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

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

THERAPEUTIC SHOES

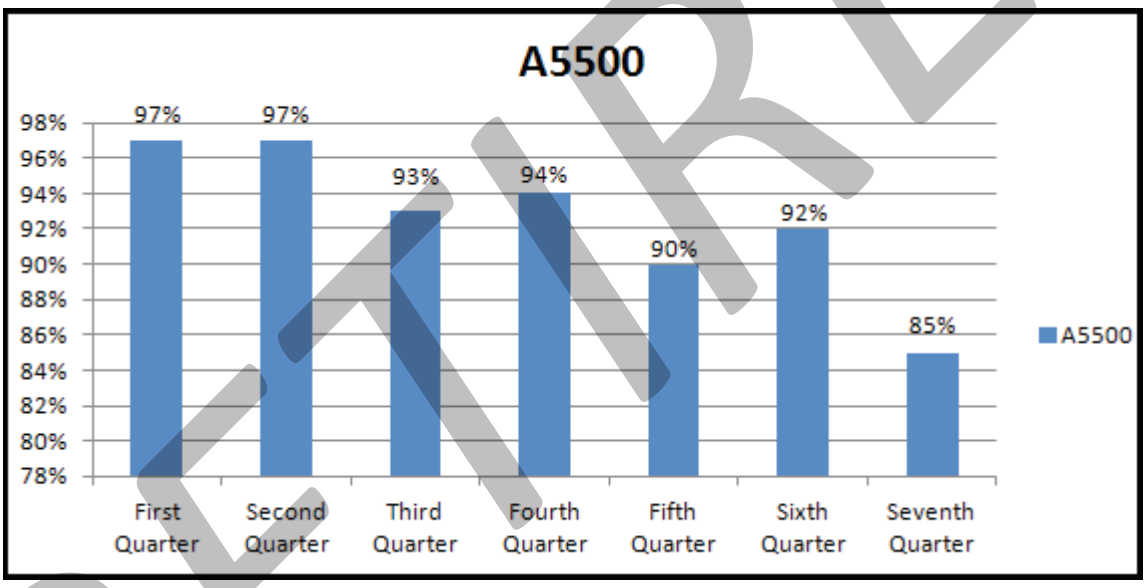
Seventh Quarter Results of Widespread Prepayment Review of Claims for Therapeutic Shoes for Persons with Diabetes (HCPCS A5500)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A5500. The seventh quarter edit effectiveness results from 3/13/2013 through 6/12/2013 are as follows:

The A5500 review involved 2,663 claims, of which 2,265 were denied. This resulted in an overall error rate of 85%.

Historical Data of the Error Rate for A5500 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 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.

- Criterion 2 not met per Policy Article (PA) A37076

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

- Previous amputation of the other foot, or part of either foot, or
- History of previous foot ulceration of either foot, or
- History of pre-ulcerative calluses of either foot, or

- Peripheral neuropathy with evidence of callus formation of either foot, or
- Foot deformity of either foot, or
- Poor circulation in either foot

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

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

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

- Criterion 3 not met per PA A37076

There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after 1/1/2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts

Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

- Criterion 4 not met - documentation of in-person visit prior to selection of item incomplete per Local Coverage Determination (LCD) L157 and PA A37076

There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

1. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications
2. For all shoes, taking measurements of the patient's feet

For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076.

THERAPEUTIC SHOES

Suppliers can also review specific policy resources for Therapeutic Shoes for Persons with Diabetes on the Noridian 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 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

VACUUM ERECTION SYSTEM

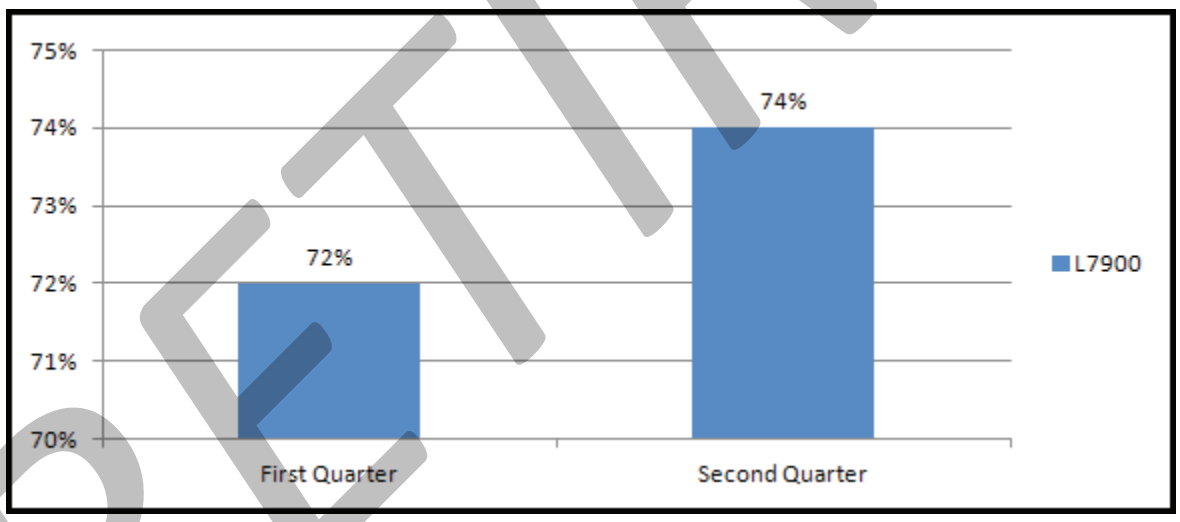
Second Quarter Results of Widespread Prepayment Review of Claims for Male Vacuum Erection System (HCPCS L7900)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L7900. The second quarter edit effectiveness results from February 13, 2013 through May 15, 2013 are as follows:

The L7900 review involved 137 claims of which 99 were denied. Based on dollars in error, this resulted in an overall error ratio of 74%.

Historical Data of the Error Rate for L7900 Review



Primary Documentation Errors that Resulted in Denial of Claims

- Documentation submitted did not support medical necessity of the item ordered

The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by

Medicare, the beneficiary's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. There must be information in the beneficiary's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

- No documentation was received

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

- The proof of delivery (POD) was invalid

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

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

Method 1—Direct Delivery to the Beneficiary by the Supplier

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

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

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

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

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

- Beneficiary's name
- Delivery address

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

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

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

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

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

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

No POD was submitted.

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

Going Forward

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

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the National Coverage Determination for Diagnosis and Treatment of Impotence NCD 230.4 , CMS Publication 100-8, Program Integrity Manual (PIM) Chapter 5 , and the Supplier Manual Chapter 3.

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

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

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