DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES •

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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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Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 a.m. – 8 p.m. CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment and CMN Status
Supplier Contact Center	1-877-320-0390	8am-6pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8am-4pm CT
Website: www.noridianmedicare.com/dme		
Fax		
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
CERT Medical Documentation		1-701-277-7890
NAS Email Addresses		
NAS DME Customer Service		dme@noridian.com
Reopenings and Redeterminations		dmeredeterminations@noridian.com
NAS DME Endeavor		dmeendeavor@noridian.com
Mailing Addresses		
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727		**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737		**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32231 -4013
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728		**DME Recovery Auditor Overpayments** Noridian Administrative Services PO Box 6759 Fargo ND 58108-6759
Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
Jurisdiction B: National Government Services	1-877-299-7900	www.ngsmedicare.com
Jurisdiction C: CGS	1-866-270-4909	www.cgsmedicare.com
Other Resources		
Pricing, Data Analysis and Coding	1-877-735-1326	www.dmepdac.com
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange Help Desk	1-866-311-9184	www.ngscedi.com
Centers for Medicare & Medicaid Services		www.cms.gov

2012 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

Supplier Contact Center

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

Event	Date	Closure Timeframe
Thanksgiving	November 22 and 23	Entire Day Closed 8:30 a.m. – 6 p.m. CT
Off-the-Phone Training	November 30	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 14	9:30 a.m. – 12 p.m. CT
Off-the-Phone Training	December 21	9:30 a.m. – 12 p.m. CT
Christmas	December 24 and 25	Entire Day Closed 8:30 a.m. – 6 p.m. CT

Telephone Reopenings

The NAS Telephone Reopening Team will be closed for the entire day (8 a.m. through 4:00 pm CT) in recognition of holidays. Additionally, the Telephone Reopening team will be closed one day each month between 8 a.m. and 12:30 p.m. CT to receive training. The holiday and training closures are provided below.

Event	Date	Closure Timeframe
Thanksgiving	November 22 and 23	Entire Day Closed 8 a.m. – 4 p.m. CT
Off-the-Phone Training	December 5	8 a.m. – 12:30 p.m. CT
Christmas	December 24 and 25	Entire Day Closed 8 a.m. – 4 p.m. CT

Alert Concerning Impacts Arising from Having Non-Compliant Physical or Practice Address Information on File with Medicare

MLN Matters® Number: SE1245

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

Provider Action Needed
The purpose of this Article is to alert physicians, providers, and suppliers that you need to ensure that your designated FI, carrier, DME MAC or A/B MAC no longer has a Post Office (P.O.) Box or Lock Box address in association with your Billing Provider Address information on file for you.

Impacts to Institutional Providers

- For 837 institutional claims, the volume of claims that receive error H25375 "The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-to Provider Address" and therefore are not crossed over for processing by another payer is approximately 7,500 claims per week.
- The problem of institutional claims rejecting with error H25375 is particularly acute for providers in Puerto Rico, some of whom unfortunately may be experiencing a 100 percent rejection rate for their institutional crossover claims.

Impacts to Physicians and Suppliers

- Nationally, by comparison, the incidence of H25375 rejections for 837 professional claims for all states and United States territories is roughly 1,000 per week.

The Accredited Standards Committee (ASC) X12 Standard for Electronic Data Interchange (EDI) Technical Report Type 3 (TR-3) Guides prohibit inclusion of a P.O. Box or Lock Box Address within the Billing Provider Address (2010AA N301 and N302) segments of any health care claims exchanged electronically between or among Health Insurance Portability and Accountability Act (HIPAA) "covered entities," which include providers, health plans, and clearinghouses.

Creation of Bill-to Provider Address Information on Outbound Medicare Coordination of Benefits (COB) Claims
Medicare uses information stored within its internal provider or supplier files for claims payment as well as for Coordination of Benefits (COB)/Medicare claims crossover purposes. Specifically, the Medicare claims processing systems use on-file physical or practice address information from these data sources in the creation of the required Bill-to Provider (2010AA) name and address elements.

The Centers for Medicare & Medicaid Services (CMS) highlighted the ongoing problem of Medicare crossover claims failing HIPAA compliance at its Coordination of Benefits Contractor (COBC) due to the presence of a P.O. Box or Lock Box within the 2010AA N301 and N302 segments at recent Provider Enrollment, Chain, and Ownership System (PECOS) conferences. This MLN Matters® Special Edition Article also alerts you to this important concern so that you can act to remedy the problem if it affects you.

If you or your billing offices are receiving provider notification letters from Medicare that reflect error H25375 as the basis for why your patients' claims cannot be crossed over—or that otherwise are encountering a 100 percent incidence of their patients' Medicare claims not being crossed over— you should contact your local jurisdictional FI, carrier, DME MAC, or A/B MAC to confirm what street address information Medicare has on file for you.

Your Medicare contractor will be able to advise you about what actions involving completion of an on-line 855 application may be necessary to ensure that PECOS and the associated internal Medicare provider and supplier files will reflect your street address for your physical address or practice address, as applicable. Make sure that your billing staffs comply with this Special Notice, if necessary.

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

Centers for Medicare & Medicaid Services Approved Clinical Trials

The Centers for Medicare & Medicaid Services (CMS), in the development of National Coverage Determinations (NCDs), created a category of "Coverage with Evidence Development." Coverage with Evidence Development (CED) provides limited Medicare coverage for beneficiaries enrolled in CMS-approved clinical trials and requires the collection of additional patient data to supplement standard claims data.

Currently CMS has published three (3) NCDs under DME MAC jurisdiction that provide for coverage under CED:

1. Transcutaneous Electrical Nerve Stimulation (NCD Manual, Chapter 1, Section 160.27);
2. Home Use of Oxygen in Approved Clinical Trials (NCD Manual, Chapter 4, Section 240.2.1)
3. Home Oxygen Use to Treat Cluster Headaches (NCD Manual, Chapter 4, Section 240.2.2)

Information regarding which clinical trials are approved by CMS under CED may be found on the CMS Web site at: http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html. Suppliers should utilize this resource in order to verify the participation of the beneficiary in a CMS-approved clinical trial and to determine the proper ClinicalTrials.Gov study identifier. As of October 5, 2012, no clinical studies involving TENS for treatment of chronic low back pain (CLBP) or home use of oxygen for cluster headaches have been approved by CMS. There is one CMS-approved study for the home use of oxygen in approved clinical trials – Long-Term Oxygen Treatment Trial (ClinicalTrials.Gov Identifier NCT00692198).

Coverage of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items for beneficiaries enrolled in CMS-approved clinical trials must meet specific documentation requirements, including providing the specific ClinicalTrials.Gov identifier. Suppliers are strongly encouraged to review the Local Coverage Determinations (LCDs) and policy articles (PAs) located on the NAS website to review the guidelines for billing and coverage when the DMEPOS item is being used for a beneficiary due to inclusion in a clinical trial. If LCDs and PAs are not available for the DMEPOS item being billed, a National Coverage Determination may be available. Suppliers can access NCDs in the Internet-Only Manual Publication 100-03, *Medicare National Coverage Determinations Manual* on the CMS web site at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

Effect of Beneficiary Agreements Not to Use Medicare Coverage and When Payment May be Made to Beneficiary for Service of Opt-Out Physician/Practitioner

MLN Matters® Number: MM8100
Related Change Request (CR) #: CR 8100
Related CR Release Date: October 26, 2012
Related CR Transmittal #: R160BP
Effective Date: January 28, 2013
Implementation Date: January 28, 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) 8100 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending Chapter 15, Section 40.6 of the "Medicare Benefit Policy Manual" to be consistent with current regulations. In addition, CMS is making some other minor changes to sections 40 through 40.40 of the same manual in order to update those sections of the manual.

Background
Section 4507 of the Balanced Budget Act of 1997 amended section 1802 of the Social Security Act ("the Act") to permit certain physicians and practitioners to opt-out of Medicare if certain conditions were met, and to provide through private contracts services that would otherwise be covered by Medicare.

The purpose of CR8100 is to modify section 40.6 of the "Medicare Benefit Policy Manual," Chapter 15, because to be consistent with the policy described in Medicare regulations at 42 CFR 405.435(c). That regulation permits Medicare payment to be made for claims submitted by a beneficiary for the services of an opt out physician or practitioner when

the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the Medicare contractor that the physician or practitioner has opted out of Medicare.

Additional Information
The official instruction, CR 8100, issued to your carrier or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and- Guidance/Guidance/Transmittals/Downloads/R160BP.pdf on the CMS website. The revised manual sections are attached to CR8100.

Hurricane Sandy and Medicare Disaster Related Claims

MLN Matters® Number: SE1247

Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in the States of New York and New Jersey who were affected by Hurricane Sandy.

What You Need to Know
On October 30, 2012, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Obama declared that, as a result of the effects of Hurricane Sandy, a major disaster exists in the State of New Jersey, retroactive to October 26, 2012. On November 1, 2012, Secretary Sebelius of the Department of Health & Human Services (HHS) declared that a public health emergency exists in the State of New Jersey and authorized waivers and modifications under Section 1135 of the Social Security Act, retroactive to October 26, 2012.

Also on October 30, 2012, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Obama declared that, as a result of the effects of Hurricane Sandy, a major disaster exists in the State of New York, retroactive to October 27, 2012. On October 31, 2012, HHS Secretary Sebelius declared that a public health emergency exists in the State of New York and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to October 27, 2012.

On November 2, 2012, the Acting Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the entire State of New Jersey, retroactive to October 26, 2012. On October 31, 2012, the Acting Administrator of CMS authorized waivers under Section 1812(f) for the entire State of New York, retroactive to October 27, 2012.

These declarations alter certain Medicare requirements in order to assure that Medicare's Fee-For-Service (FFS) beneficiaries affected by this disaster will have timely access to needed health care services. See the Background section of this article for more details.

Background
Section 1135 and Section 1812(f) Waivers
As a result of the aforementioned declarations, CMS has instructed Medicare contractors as follows:

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of New Jersey from October 26, 2012, for the duration of the emergency. CR6451 also applies to items and services furnished to Medicare beneficiaries within the State of New York from October 27, 2012, for the duration of the emergency. In accordance with CR6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. Medicare FFS Questions & Answers (Q&As) posted on the CMS website are applicable for items and services furnished to Medicare beneficiaries within the States of New Jersey and New York. These Q&As are displayed in two files. The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in New York and New Jersey. The second file addresses policies and procedures that are applicable only witha Section1135 waiver or, when applicable, a Section 1812(f) waiver. These Q&As are effective October 26, 2012, for New Jersey and October 27, 2012, for New York. In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information revised.

a. Q&As applicable without any Section 1135 or other formal waiver are available at http://www.cms.gov/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf on the CMS website; and

b. Q&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver, are available at http://www.cms.gov/Emergency/downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf on the CMS website.

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of New York and New Jersey. Individual facilities do not need to apply for the following approved blanket waivers:

All Providers

- Bed Capacity: The states of New York and New Jersey are authorized to process certified bed increases for hospitals and nursing homes, per the request from the facility.
- CMS has suspended onsite survey activities (except for investigations of immediate jeopardy allegations) in areas impacted by the storm.

Skilled Nursing Facilities

- Waiver of 3-day prior hospitalization under Section 1812(f) for coverage of a Skilled Nursing Facility stay (Blanket waiver)
- 42 CFR 483.20: Timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities)

Home Health Agencies

- 42 CFR 484.20(c)(1): OASIS Transmission timeframes (Blanket waiver for all impacted agencies)
- 42 CFR 484.36(d)(2): Two Week Aide Supervision requirements by an RN (Blanket waiver for all impacted agencies)
- Home health agencies should monitor information posted at http://www.cms.gov/Emergency for updates on waivers.

Hospice

- 42 CFR 418.76: Supervision of Hospice Aides every 14 days by a registered nurse (Blanket waiver for all impacted agencies)
- Hospice agencies should monitor information posted at http://www.cms.gov/Emergency for updates on waivers related to hospice providers.

End Stage Renal Disease (ESRD)

In response to concerns about dialyzing ESRD patients on an outpatient basis, CMS clarified that when an ESRD patient who cannot obtain his or her regularly scheduled dialysis treatment at a certified ESRD facility and has a medical need to receive an unscheduled or emergency dialysis session in an outpatient hospital setting, the service is payable under the Outpatient Prospective Payment System (OPPS).

Disclosure of Health Insurance Claim Number (HICN) for Provider Billing Over the Telephone During a Public Health Emergency

During a public health emergency, CMS recognizes that a beneficiary may present to a Medicare provider without his or her HICN. Therefore, under these circumstances only Medicare contractors may disclose the HICN to a provider, in order to bill Medicare when the provider gives four pieces of beneficiary identifying information. These may include: Social Security Number (SSN), date of birth, address on file, telephone number, effective date(s) of Medicare entitlement, and whether the beneficiary has Part A and/or Part B coverage.

Medicare contractors should still make every effort to obtain four pieces of identifying information, including the HICN, during a Public Health Emergency (PHE). However, if the HICN is not known, it may be any four pieces of identifying information. In situations where the provider is unable to provide four pieces of identifying information, the contractor should use professional judgment to determine whether or not the release of the HICN is appropriate under the circumstances.

In addition, the contractor must make every attempt to verify that the person requesting the HICN is the provider of service. The contractor should use the Provider Enrollment, Chain and Ownership System (PECOS) to verify the provider's SSN, date of birth, and Provider Transaction Access Number (PTAN). For organizational providers, the contractor should use PECOS to verify the name of the authorized or delegated official on file for the provider.

Additional Information
The Federal Emergency Management Agency (FEMA) website is available at http://www.fema.gov/sandy on the Internet. It contains information on special disaster assistance, including the availability of emergency shelters for those who are unable to remain in or return to their homes due to the disaster.

For assistance, New York providers may contact the New York State Department of Health's special emergency hotline number at (866) 544-1303. New Jersey providers may contact the New Jersey State Department of Health's special emergency hotline number at (866) 234-0964.

Additional CMS-specific information on Hurricane Sandy is available on the CMS Emergency web page at http://www.cms.gov/Emergency on the CMS website. This web page includes links to the following documents:

- Provider Survey and Certification Frequently Asked Questions (FAQs);
- Section 1135 Waiver Summary and Q&As;
- Medicare FFS Emergency Q&As (applicable without a Section 1135 or other formal waiver);
- Medicare FFS Emergency Q&As (applicable a Section 1135 or other formal waiver); only with a Section 1135 or, when applicable, an 1812(f) waiver); and
- Health Emergency Declarations and Waivers.

Medicare Guidance Regarding Meningitis Outbreak

MLN Matters® Number: SE1246

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

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) is providing direction to Medicare contractors based on the Centers for Disease Control and Prevention's (CDC) interim treatment guidance for Central Nervous System (CNS). This guidance is also related to parameningeal infections and septic arthritis associated with contaminated steroid products produced by the New England Compounding Center (NECC). This guidance is available on the CDC website at http://www.cdc.gov/hai/outbreaks/clinicians/index.html on the Internet.

The CDC recommends diagnostic and therapeutic activities for symptomatic patients. Therefore, CMS believes that, aside from oral drugs, items and services to diagnose and treat patients who have received contaminated medications qualify for the Medicare Part A or Part B benefit.

CMS urges all Medicare contractors to review the CDC website at http://www.cdc.gov/hai/outbreaks/clinicians/faq_meningitis_outbreak.html regularly for updates and specific actions they should take to ensure timely access to CDC recommended items and services.

Due to the severity of this situation, CMS advises providers that Medicare contractors are expected to expedite all coverage determination requests for these items and services to include antifungal medication.

The CDC has identified the following states as having received potentially-contaminated steroid products:

California	Michigan	Pennsylvania
Connecticut	Minnesota	Rhode Island
Florida	Nevada	South Carolina
Georgia	New Hampshire	Tennessee
Idaho	New Jersey	Texas
Illinois	New York	Virginia
Indiana	North Carolina	West Virginia
Maryland	Ohio	

While clinics in these states received contaminated products, patients in additional states may be affected. Check the CDC's Multistate Fungal Meningitis Outbreak Investigation web page regularly for the latest news and information about the outbreak. The website is available at: http://www.cdc.gov/hai/outbreaks/clinicians/faq_meningitis_outbreak.html on the Internet.

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."

New Health Care Standards To Save Up To $6 Billion

Currently, when a health care provider bills a health plan, that plan may use a wide range of different identifiers that do not have a standard format. As a result, health care providers run into a number of time-consuming problems, such as misrouting of transactions, rejection of transactions due to insurance identification errors, and difficulty determining patient eligibility. The change announced on August 24 will greatly simplify these processes.

The rule also makes final a one-year proposed delay,– from October 1, 2013 to October 1, 2014 – in the compliance date for use of new codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that improve the quality of information available for quality improvement and payment purposes.

The rule announced today is the fourth administrative simplification regulation issued by HHS under the health reform law:

- On July 8, 2011, HHS adopted operating rules for two electronic health care transactions to make it easier for health care providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer. The rules will save up to $12 billion over ten years.
- On January 10, 2012, HHS adopted standards for the health care electronic funds transfers (EFT) and remittance advice transaction between health plans and health care providers. The standards will save up to $4.6 billion over ten years.
- On August 10, 2012, HHS published an IFC that adopted operating rules for the health care EFT and electronic remittance advice transaction. The operating rules will save up to $4.5 billion over ten years.

More information:

- Fact sheet
- Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets Final Rule

Full text of this excerpted CMS press release (issued August 24).

Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)

MLN Matters® Number: SE1128 Revised

Note: This article was revised on August 28, 2012, to clarify the section of the Social Security Act that prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing (page 2- bold).This article was previously updated on July 25, 2012, to reflect current Web addresses. All other content remains the same.
All Medicare physicians, providers and suppliers who submit claims to Medicare for services and supplies provided to Qualified Medicare Beneficiaries (QMBs) are affected. This includes providers of services to enrollees of Medicare Advantage plans.

What You Need to Know
This Special Edition MLN Matters® Article provides guidance from the Centers for Medicare & Medicaid Services (CMS) to Medicare providers serving QMBs. All Medicare providers are reminded that they may not bill QMBs for Medicare cost-sharing.

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as "balance billing." Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the State Medicaid Agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

Background
This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. This is known as "balance billing."

Balance Billing of QMBs Is Prohibited by Federal Law
Under current law, Medicare providers cannot balance bill a QMB. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing. (Please note, this section of the Act is available at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm on the Internet.)

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

Please note that the statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect, and therefore, may be causing confusion about QMB billing.

QMBs and Benefits
QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the State's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits.
- Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Ways to Improve the Claims Process
Effective communications between you and State Medicaid Agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with State Medicaid Agencies and better understand the billing process for services provided to QMB beneficiaries:

1. Determine if the State in which you operate has electronic crossover processes with the Medicare Coordination of Benefits Contractor (COBC) in place or if direct submission to the State Medicaid Agency is required or available. Nearly all States participate in the Medicare crossover process. It may just be that particular QMBs need to be added to the eligibility exchange between given States and Medicare. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
2. Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the State payment system.

3. Understand the specific requirements for provider registration for the State(s) in which you work.
4. Contact the State Medicaid Agency directly to determine the process you need to follow to begin submitting claims and receiving payment.

QMB Eligibility and Benefits

Dual Eligibility	Eligibility Criteria	Benefits
Qualified Medicare Beneficiary (QMBonly)	Income cannot exceed 100% of the Federal Poverty Level (FPL) Resources cannot exceed $6,600 for a single individual or $9,910 for an individual living with a spouse and no other dependents	Entitled to Medicare Part A Eligible for Medicaid payment of Medicare Part B premiums, deductibles, co-insurance and co-pays (except for Part D)
QMB Plus	Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage Individuals often qualify for full Medicaid benefits by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.	Entitle to all benefits available to QMB, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient

For more information about dual eligible categories and benefits, please visit http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf on the Internet.

Additional Information
For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)," which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf on the CMS website.

For general Medicaid information, please visit the Medicaid web page at http://www.medicaid.gov/index.html on the CMS website.

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

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

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate NAS' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from CMS. Whenever NAS publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. NAS includes "Source" following CMS derived articles to allow for those interested

in the original material to research it at CMS's website, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

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

Supplier Contact Center Hours Change to 8 a.m. – 6 p.m. CT

To further serve our customers, the NAS DME Jurisdiction D Supplier Contact Center will be extending its hours to open at 8 a.m. CT on October 15, 2012. The Contact Center will maintain its 6:00 p.m. CT closing.

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
9	ADMC	Added manual wheelchair HCPCS codes	10/29/12
13	Administrative Law Judge	Updated ALJ address	10/24/12
Appendix	Contacting NAS and Inquiries Resources	Updated Supplier Contact Center Hours	10/15/12
8	Step 6	Change "supplier" to "supplier's vendor or clearinghouse"	09/11/12
8	Benefits	Updated 999 Functional Acknowledgement and CEDI 277CA Claim Acknowledgement	09/11/12
15	Immediate Recoupment Process	Added this new section	09/05/12

Termination of the Common Working File ELGB Provider Query

MLN Matters® Number: MM8086
Related Change Request (CR) #: 8086
Related CR Release Date: November 2, 2012
Related CR Transmittal #: R1140OTN
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

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

Provider Action Needed
This article is based on Change Request (CR) 8086 which informs Medicare contractors about the changes being made to eliminate the ELGB (eligibility) query. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Medicare providers use the Common Working File (CWF) ELGB query to obtain Medicare beneficiary information. However, the Centers for Medicare and Medicaid Services (CMS) must eliminate this query capability because the ELGB query is not HIPAA compliant because the incoming query and the outgoing response are not in X12 format. CMS is required by HIPAA to use the proper format when exchanging this information with any covered entity, which applies to all users of this query. As a result, CMS is eliminating this query. They can no longer support the approach of allowing providers online access to CWF non-HIPAA compliant data.

FYI CONT'D

While the CWF ELGB query is discontinued, other query capabilities, such as the HIPAA Eligibility Transaction System (HETS), are available. More information on HETS is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html on the CMS website. You may also use your Medicare contractor's Integrated Voice Response (IVR) System or their Web portal.

Additional Information
The official instruction, CR8086 issued to your carrier, DME MAC, and B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1140OTN.pdf on the CMS website.

APPEALS

Reminder: Signature Required on Redetermination Requests

NAS continues to receive numerous redetermination requests without a proper signature of the requesting party. **Digital signatures are only accepted via a secure internet portal. NAS' secure internet portal is Endeavor**. Effective July 1, 2007, all redetermination requests received without the appellant's signature are being dismissed as incomplete requests.

CMS has provided guidelines on the required information, including the signature of the requesting party, in the Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions, Section 310.1.B.3, Filing a Request for Redeterminations.

For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as outlined below:

- A written signature may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An electronic, digital, and/or digitalized signature is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application.
- A stamp signature or other indication that a 'signature is on file' on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request shall not be considered a acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

Telephone Reopenings: What Can and Cannot be Requested

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

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

How do I request a telephone reopening?	**Requesting a telephone reopening is simple, call 1-888-826-5708.**
What are the hours of operation for the telephone reopenings?	Monday through Friday 8 a.m. until 4 p.m. CT (Closed 11:45 a.m. – 12:30 p.m. CT) Additional closing information can be found at https://www.noridianmedicare.com/dme/contact/holiday.html.

How do I request a telephone reopening?	Requesting a telephone reopening is simple, call 1-888-826-5708.
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.

APPEALS CONT'D

How do I request a telephone reopening?	Requesting a telephone reopening is simple, call 1-888-826-5708.
What is not accepted as a telephone reopening?	The following will not be accepted as a telephone reopening. These items must be submitted along with all supporting documentation as a redetermination. • Any item billed over the allowance listed in the medical policy – documentation is required to support amount billed • Parenteral and enteral DIF issues • Oxygen BIS • Wheelchairs/power mobility devices – HCPCS K0005 and higher • Recoupment/reduction of payment – complete Refunds to Medicare form • Medicare Secondary Payer (MSP) – send inquiry to MSP department • Timely denials – claims submitted within appropriate time frame • Late files – reopening and/or redetermination requests submitted within the appropriate time frame • Requests that require documentation • Advance Beneficiary Notice of Noncoverage (ABN) issues • A1–A9 modifiers • GA modifier • GY modifier • GZ modifier • KX modifier • HCPCS codes J1559, J1561, J1562 • Liability issues • Repairs to equipment • Miscellaneous codes • Labor codes **NOTE:** Claims with remittance message MA130 can never be submitted as a reopening. Claims with message MA130 are considered unprocessable and do not have reopening or redetermination rights. The claim is missing information that is needed for processing the claim or the claim information is invalid. These claims must be resubmitted with a new corrected claim.
What do I do when I have a large amount of the same correction?	In the event that a supplier has more than 50 of the same correction, that is able to completed as a reopening, NAS encourages the supplier to notify the telephone representative. The telephone representative will gather the required information and provide the supplier with direction on what is needed and how to submit the request.
Where can I find more information on telephone reopenings?	Suppliers can utilize NAS website at https://www.noridianmedicare.com/dme, specifically • Supplier Manual, Chapter 13: https://www.noridianmedicare.com/dme/news/manual/chapter13.html • Appeals page: https://www.noridianmedicare.com/dme/appeals/
Additional Assistance Available	**Suppliers can email questions and concerns regarding reopenings and redeterminations to** dmeredeterminations@noridian.com, excluding any Protected Health Information (PHI) information.

2013 Annual Update of HCPCS Codes for SNF Consolidated Billing Update

MLN Matters® Number: MM8037
Related Change Request (CR) #: CR 8037
Related CR Release Date: September 7, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2542CP
Implementation Date: January 7, 2013

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

Provider Action Needed
If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in CR8037 could impact your payments.

This article is based on Change Request (CR) 8037 which provides the 2013 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2012:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2013 Carrier/A/B MAC Update) will be posted at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill Fiscal Intermediaries or A/B MACs are advised that new Excel and PDF files (entitled 2013 FI/A/B MAC Update) will be posted to http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html on the CMS website.

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

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

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

Additional Information
The official instruction, CR8037 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2542CP.pdf on the CMS website.

Claim Adjustment Reason Code, Remittance Advice Remark Code, and Medicare Remit Easy Print and PC Print Update

MLN Matters® Number: MM8029
Related Change Request (CR) #: CR 8029
Related CR Release Date: August 17, 2012
Related CR Transmittal #: R2521CP
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 8029 which instructs Medicare contractors and Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been added since the last recurring code update. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA; see http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf on the Internet), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice (RA), there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 8029, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only 3 times a year and may not match the CMS release schedule.

CR 8029 lists only the changes that have been approved since the last code update provided by CR 7775 (Transmittal 2442 issued on April 6, 2012; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf on the CMS website).

CR 8029 does not provide a complete list of CARCs and RARCs, and the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website which is updated three times a year (around March 1, July 1, and November 1).

The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (see http://www.wpc-edi.com/Reference) has four listings available of Codes by Status for both CARC and RARC.

1. **Show All:** All codes including current, to be deactivated and deactivated codes are included in this listing.
2. **Current:** Only currently valid codes are included in this listing.
3. **To Be Deactivated:** Only codes to be deactivated at a future date are included in this listing.
4. **Deactivated:** Only codes with prior deactivation effective dates are included in this listing.

NOTE 1: In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

NOTE 2: CR8029 lists only the changes approved since the last recurring Code Update CR once. If any change becomes effective at a future date, Medicare contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC website. If the effective date per the WPC website does not match any quarterly release date, Medicare contractors may update earlier than the effective date per WPC website for any deactivation, and later than the effective date per WPC website for any modification or new code.

CARCs

A national code maintenance committee maintains the health care CARCs, and a new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare.

This code set is updated three times a year, and the updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of January/February, June, and September/October.

The full list of CARCs can be found and downloaded from http://wpc-edi.com/Reference and to find out more about CARCs, see the "Medicare Claims Processing Manual" (Chapter 22, Sections 60.1 and 130.2 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf on the CMS website.

New CARCs were approved by the Code Committee, and the following changes were made in the CARC database since the last code update provided by CR 7775. These changes must be implemented, if appropriate for Medicare, by October 1, 2012.

New CARCs

Code	Code Narrative	Effective Date
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/3/2012
241	Low Income Subsidy (LIS) Co-payment Amount.	6/3/2012
242	Services not provided by network/primary care providers.	6/3/2012
243	Services not authorized by network/primary care providers.	6/3/2012

Modified CARCs

Code	Code Narrative	Effective Date
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. Use Group Code OA.	6/3/2012

Deactivated CARCs

Code	Code Narrative	Effective Date
38	Services not provided or authorized by designated (network/ primary care) providers.	1/1/2013

Remittance Advice Remark Codes (RARCs)
Remittance Advice Remark Codes (RARCs) are maintained by CMS and may be used by any health plan when they apply. Medicare contractors must report appropriate remark code(s) that apply in both electronic and paper remittance advice, and COB claims. RARCs are used in a remittance advice to further explain an adjustment in conjunction with an appropriate CARC or relay general information about the adjudication process.

The remark code list is updated three times a year, and the list as posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. Medicare contractors must use the currently valid remark codes as included in the Recurring Update Notification and/or any other CMS instruction. Medicare contractors also must get the full list of RARCs by downloading the list from the WPC website after each update. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or introduction of newly created codes that may impact Medicare.

The list of Remittance Advice Remark Codes (RARCs) can be found at http://www.wpc-edi.com/codes on the Internet.

For more information about Remark Codes
You can find out more about CARCs in the "Medicare Claims Processing Manual" (Publication 100-04, Chapter 22, Section 60.2, and 130.3 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf on the CMS website.

These following changes were made in the RARC database since the last code update provided by CR 7775. The full RARC list must be downloaded from the WPC website at http://wpc-edi.com/Reference on the Internet.

New RARCs

Code	Code Narrative	Effective Date
N554	Missing/Incomplete/Invalid Family Planning Indicator	7/1/2012
N555	Missing medication list.	7/1/2012
N556	Incomplete/invalid medication list.	7/1/2012
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	7/1/2012
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	7/1/2012
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.	7/1/2012

Modified RARCs

Code	Modified Code Narrative	Effective Date
N69	PPS (Prospective Payment System) code changed by claims processing system.	7/1/2012
N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	7/1/2012

Deactivated RARCs

None

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the Business

Requirements segment of CR8029 for explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional Information
The official instruction, CR8029, issued to your contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2521CP.pdf on the CMS website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM7905
Related Change Request (CR) #: CR 7905
Related CR Release Date: August 2, 2012
Related CR Transmittal #: R2508CP
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

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

What You Need to Know
This article is based on Change Request (CR) 7905 which explains that the Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at http://www.wpc-edi.com/content/view/180/223/ on the Internet. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting should have been posted on that site on or about July 1, 2012.

Background
HIPAA requires all health care benefit payers to use Claim Status Category Codes and Claim Status Codes to report the status of submitted claim(s). Only codes approved by the National Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at http://www.wpc-edi.com/content/view/180/223/ (previously http://www.wpc-edi.com/codes) on the Internet. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by October 1, 2012.

Additional Information
The official instruction, CR7905, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and- Guidance/Guidance/Transmittals/Downloads/R2508CP.pdf on the CMS website.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8045
Related Change Request (CR) #: CR 8045
Related CR Release Date: September 14, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2547CP
Implementation Date: January 7, 2013

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

Provider Action Needed
This article, based on Change request (CR) 8045, explains that Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277, Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the national Code Maintenance Committee meetings.

These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ or http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ on the Internet. Make sure that your billing staffs are aware of these updates.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use. All code changes approved during the June 2012 committee meeting will be posted on the Internet on or about July 1, 2012.

Additional Information
The official instruction, CR8045, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.hhs.gov/Regulations-and- Guidance/Guidance/Transmittals/Downloads/R2547CP.pdf on the CMS website.

Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation, MSP Claims

MLN Matters® Number: MM7355 Revised
Related Change Request (CR) #: 7355
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R87MSP
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Note: This article was revised on August 3, 2012, to reflect the revised CR7355 issued on August 3. In the article, the CR release date, transmittal number, effective and implementation dates (see above), and the Web address for accessing CR7355 were revised. In addition, a reference to remittance advice remark code M32 was deleted. All other information is the same.

Provider Types Affected
This MLN Matters® article is intended for physicians, hospitals, Home Health Agencies, and other providers who bill Medicare Carriers, Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B/MACs); and suppliers who bill Durable Medical Equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self insurance), no-fault insurance, and WC Medicare Second Payer (MSP) claims.

Provider Action Needed
This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC Medicare Secondary Payer (MSP) claims. Not following the procedures identified in this article may impact your reimbursement. Change Request (CR) 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background
CR7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

The term Group Health Plan (GHP) as related to this MLN article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term Non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key Points

Conditional Medicare Payment Procedures
Medicare may not make payment on a MSP claim where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance.

Medicare can make conditional payments for both Part A and Part B WC, or no-fault, or liability insurance (including self insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self insurance) and the promptly period has expired. Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver, or release [whether or not there is a determination or admission of liability for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

"Promptly" Definition

No-fault Insurance and WC "Promptly" Definition
For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

Liability Insurance "Promptly" Definition
For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.
- The "Medicare Secondary Payer (MSP) Manual" (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c01.pdf), Chapter 1 (Background and Overview), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: For the liability situation, the MSP auxiliary record is usually posted to the Medicare's Common Working File (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort (civil wrong)) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare's CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the Liability record was created on Medicare's CWF to be the date the general liability claim was filed.

How to Request a Conditional Payment
The following summarizes the technical procedures that Part A, and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A Conditional Payment Requests
Providers of Part A services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 Institutional Electronic Claim, using the appropriate insurance value code (i.e., value code 14, 15 or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, Providers must identify the other payer's identity on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or Remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 Institutional Claims, Providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate Occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., Liability, no-fault and Workers' Compensation) situations, but the primary payer did not make a payment in the promptly period). Note: Beginning July 1, 2012 Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is requesting conditional payments.

Table 1: Data Requirements for Conditional Payment for Part A Electronic Claims

Type of Insurance	CAS	Part A Value Code (2300 HI)	Value Amount (2300 HI)	Occurrence Code (2300 HI)	Condition Code (2300 HI)
No-Fault/ Liability	2320 – valid information shy NGHP or GHP did not make payment	14 or 47	$0	01 – Auto Accident & Date 02 – No-fault Insurance Involved & Date 24 – Date Insurance Denied	
WC	2320- valid information why NGHP or GHP did not make payment	15	$0	04 – Accident/ Tort Liability & Date 24 – Date Insurance Deneid	02 – Condition is Employment Related

Part B Conditional Payment Requests (Table 2)
Since the electronic Part B claim (837 4010 professional claim) does not contain Value Codes or Condition Codes, the physician or supplier must complete the: 1) 2320AMT02 = $0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor can determine if conditional payment should be granted for Part B services related to the accident or injury.

For Version 4010, Physicians and other suppliers may include CP- Medicare Conditionally Primary, AP-auto insurance policy, or OT- other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM - automobile medical, LI - Liability, LM - Liability Medical or WC - Workers' Compensation Health Claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. Note: Beginning July 1, 2012 Medicare contractors will no longer accept 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 2 displays the required information for a MSP 4010 Professional in which a physician/supplier is requesting conditional payments.

Table 2: Data Requirements for Conditional Payments for MSP 4010 Professional Claims

Type of Insurance	CAS	Insurance Type Code (2320 SBR05)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2000B SBR05)	Date of Accident
No-Fault/ Liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value EM

Please note that for 837 5010 Professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in Table 3.

Table 3: Data Requirements for Conditional Payment for 837 5010 Professional Claims

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2300 HI)	Date of Accident
No-Fault/ Liability	2320 or 2430 valid information why NGHP or GHP did not make payment	14/47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	15	WC	$0.00	02 – Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value EM

Note: Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.

Situations Where a Conditional Payment Can be Made for No-Fault and WC Claims
Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service;
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first; and
- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

Situations Where a Conditional Payment Can be Made for Liability (including Self Insurance) Claims
Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service;
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self insurer) did not make payment on the claim during the promptly period.

Conditional Primary Medicare Benefits Paid When a GHP is a Primary Payer to Medicare
Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are NOT present:

- It is alleged that the GHP is secondary to Medicare;
- The GHP limits its payment when the individual is entitled to Medicare;
- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over;
- If the GHP asserts it is secondary to the liability (including self insurance), no-fault or workers' compensation insurer.

Situations Where Conditional Payment is Denied

Liability, No-Fault, or WC Claims Denied

1. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - You did not send the claim to the employer GHP first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.
2. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial Codes
To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim Adjustment Reason Code 22 - "This care may be covered by another payer per coordination of benefits" and
- Remittance Advice Remark Code MA04 -Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Additional Information
You can find official instruction, CR7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R87MSP.pdf on the CMS website.

You will find the following revised Chapters of the "Medicare Secondary Payer Manual," as an attachment to that CR:

Chapter 1 (Background and Overview):

- Section 10.7 (Conditional Primary Medicare Benefits),

- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements):

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

Date Span Over Calendar Years Acceptable for DME Claim Submission

When billing DMEPOS claims to Medicare for items/services that span between two years, date spans may be submitted. For example, claims with a date span of December 15, 2011, to January 15, 2012, will be accepted into the claims processing system.

Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)

MLN Matters® Number: SE1011 Revised

Note: This MLN Matters® Article was revised on September 17, 2012, to change the reference to Certified Clinical Nurse Specialist on page 3 to say Clinical Nurse Specialist. Also, we have added a reference to MLN Matters® Article SE1221 in the Additional Information section of the article. All other information remains the same.

Provider Types Affected

This Special Edition MLN Matters® Article is intended for physicians, non-physician practitioners (including interns, residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), Part A Regional Home Health Intermediaries, Fiscal Intermediaries who still have a Home Health Agency (HHA) workload and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare.. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staffs are aware of these updates.

What Providers Need to Know

Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim, but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web, require verification of the information reported.

Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the ordering/referring provider edits.

Background
The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures; and
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
- Physician Assistant,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,
- Interns, Residents, and Fellows,
- Certified Nurse Midwife, and
- Clinical Social Worker.

Questions and Answers Relating to the Edits

1. What will the edits do?
   The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and it contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).
2. Why did Medicare implement these edits?
   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.
3. How and when will these edits be implemented?
   These edits are being implemented in two phases:
   - **Phase 1**: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message1 in the Medicare Remittance Advice2

1 The informational messages vary depending on the claims processing system. indicating that the claim failed the ordering/referring provider edits.

2 DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

- **Phase 2** CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. In Phase 2, if the Ordering/Referring Provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. The denial edits are identified below:

Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237 - This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.3

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a bi-weekly basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

3 NPIs were added only when the matching criteria verified the NPI.

Effect of Edits on Providers

a. I order and refer. How will I know if I need to take any sort of action with respect to these two edits? In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you—the Ordering/Referring Provider—need to ensure that:

1. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI; (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or (3) use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
- If you do not have an enrollment record in Medicare:
  You need to submit an enrollment application to Medicare in one of two ways:

  a. Use Internet-based PECOS to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to either e-sign the certification statement or mail a printed, signed, and dated Certification Statement and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

  b. Submit an electronic application through the use of internet-based PECOS or obtain a paper enrollment application, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html).

NOTE about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

2. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program

b. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?
As the Billing Provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the edits on the Ordering/Referring Provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have Medicare enrollment records that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced bi-weekly to ensure it is current. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may appeal a claim that did not initially pass the Ordering/Referring provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits. Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

Billing Providers should be aware that claims that are denied because they failed the Ordering/Referring Provider would expose the Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate.

Additional Guidance

1. A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. Orders or referrals by interns or residents. The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.
3. Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare. These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. Orders or referrals by dentists. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information
You may want to review MLN Matters® Article SE1201 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf) and SE1221 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1221.pdf) for important reminders on the requirements for Ordering and Referring Physicians.

Handling Form CMS-1500 Claims Where ICD-9-CM "E" Code is Reported as First Diagnosis on Claim

MLN Matters® Number: MM7700
Related Change Request (CR) #: 7700
Related CR Release Date: August 8, 2012
Related CR Transmittal #: R2515CP
Effective Date: Claims received with an "E" code on or after January 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected
Physicians, providers, and suppliers who submit Medicare claims to Medicare Carriers, Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment MACs (DME MACs) using the paper claim Form CMS-1500.

Provider Action Needed
This Change Request (CR) 7700 provides new instructions to return as unprocessable claims submitted on the Form CMS-1500 where an ICD-9-CM "E" Code (external causes of injury and poisoning) is reported as the first/principal diagnosis on the claim.

Background
CR7700 will bring the policy for handling form CMS-1500 claims into alignment with the policy for handling claims initially submitted in electronic format. The ICD-9-CM code set prohibits an "E" code from being reported as principal diagnosis (first-listed) on a claim. This guidance also applies to V00-Y99 (external causes of morbidity) equivalent ICD-10 CM diagnosis codes. Therefore, if an "E" code or V00-Y99 range ICD-10 CM diagnosis code is the first listed diagnosis code on the CMS-1500, the claim would not conform to the ICD-9-CM code set and electronic transmission of the electronic claim to a Coordination of Benefits Agreement (COBA) trading partner would not be Health Insurance Portability and Accountability Act (HIPAA) compliant.

Claims initially submitted as electronic claims will, effective April 1, 2012, be rejected in accordance with an edit established by CMS CR7596 when the principal (first) diagnosis code presented in the diagnosis code field is an "E" code or, effective with the implementation of ICD-10, when the principal (first) diagnosis is a code within the code range V00-Y99 of the ICD-10- CM code set. This procedure will prevent those non-HIPAA compliant claims from being adjudicated and then transmitted to the Coordination of Benefits Contractor (COBC) for COBA crossover purposes. CR7700 applies this reasoning to claims submitted on CMS-1500 on or after January 1, 2013.

Key Points
Be aware of the following:

- For claims received via form CMS-1500 on or after April January 1, 2013, Medicare contractors will return as unprocessable claims for items or services where a diagnosis code is required and the diagnosis code reported in the Number 1 field of Item 21 of the Form CMS-1500 is an ICD-9-CM "E" code (external causes of injury and poisoning) or, upon ICD-10 implementation, an ICD-10 CM code within the code range of V00-Y99
- Reprocessed/adjustment claims failing these edits will be denied.
- Claims returned or denied as a result of these edits will show remittance advice remarks code message MA63 (Missing/incomplete/invalid principal diagnosis) and claim adjustment reason code 16 (Claim/service lacks information which is needed for adjudication).

Additional Information
The official instruction, CR7700, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2515CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Important Reminder about Medicare Secondary Payer Laws

MLN Matters® Number: SE1227

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and other suppliers that are taking payment from beneficiaries upon an office or hospital visit when the Medicare beneficiary has a group health plan that is primary to Medicare. The Centers for Medicare & Medicaid Services (CMS) is issuing this article as an important reminder and the article reflects no change in current Medicare policy.

Provider Action Needed
This article is based on information received from Medicare contractors (carriers and Medicare Administrative Contractors (MACs) indicating that physicians, providers and other suppliers are requesting a Medicare deductible, coinsurance payment, or other payments from a beneficiary prior to or at the time of services being rendered when another payer is primary to Medicare.

It is against the Medicare Secondary Payer laws to accept payment from a beneficiary upon admission or when services are being rendered when another insurer is primary to Medicare. If you are performing this practice, you must stop immediately.

Participating Medicare providers, physicians, and other suppliers must not accept from the beneficiary any co-payment, coinsurance, or other payments, upon services rendered when the primary payer is an employer Managed Care Organization (MCO) insurance, or any other type of primary insurance such as an employer group health plan. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary, if anything, after Medicare makes its payment. NOTE: In situations where you have taken payment from the beneficiary when services were rendered, the beneficiary has the right to recoup his/her payment from you when reimbursement is warranted.

Background
Section 1862(b)(2)(A)(i) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to: (i) A beneficiary entitled to Medicare on the basis of ESRD during the first 30 months of that entitlement; (ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or (iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

Important Reminder about Medicare Secondary Payer Laws

MLN Matters® Number: SE1227

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and other suppliers that are taking payment from beneficiaries upon an office or hospital visit when the Medicare beneficiary has a group health plan that is primary to Medicare. The Centers for Medicare & Medicaid Services (CMS) is issuing this article as an important reminder and the article reflects no change in current Medicare policy.

Provider Action Needed
This article is based on information received from Medicare contractors (carriers and Medicare Administrative Contractors (MACs) indicating that physicians, providers and other suppliers are requesting a Medicare deductible, coinsurance payment, or other payments from a beneficiary prior to or at the time of services being rendered when another payer is primary to Medicare.

It is against the Medicare Secondary Payer laws to accept payment from a beneficiary upon admission or when services are being rendered when another insurer is primary to Medicare. If you are performing this practice, you must stop immediately.

Participating Medicare providers, physicians, and other suppliers must not accept from the beneficiary any co-payment, coinsurance, or other payments, upon services rendered when the primary payer is an employer Managed Care Organization (MCO) insurance, or any other type of primary insurance such as an employer group health plan. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary

payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary, if anything, after Medicare makes its payment. NOTE: In situations where you have taken payment from the beneficiary when services were rendered, the beneficiary has the right to recoup his/her payment from you when reimbursement is warranted.

Background
Section 1862(b)(2)(A)(i) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to: (i) A beneficiary entitled to Medicare on the basis of ESRD during the first 30 months of that entitlement; (ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or (iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers

MLN Matters® Number: SE1201 Revised

Note: This article was revised on September 19, 2012, to add a statement at the top of page 3 regarding Optometrists. The article also now contains a reference to MLN Matters® Article SE1221 and all Web addresses have been updated. All other information remains the same.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual National Provider Identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background
CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Portable X-Ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. Portable X-Ray services ordered by any other practitioners will be denied.
- Optometrists may only order and refer laboratory and X-Ray services.

MLN Matters® Special Edition Articles SE1011 and SE1221 provide further details about edits on the ordering/referring provider information on claims. SE1011 is available at http://www.cms.gov/Outreach-and-Education/

Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf and SE1212 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf on the CMS website.

Additional Information
For more information about the Medicare enrollment process, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf on the CMS website.

MLN Matters® Article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf on the CMS website.

MLN Matters® Article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf on the CMS website.

MLN Matters® Article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf on the CMS website.

MLN Matters® Article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf on the CMS website.

N544 Alert Messages – Are you Billing for Services Ordered By Providers Not in PECOS?

Many suppliers are receiving the Remark Code N544 warning message on their remittance advice. This is the first trigger to let a supplier know the ordering provider was not enrolled as a current Medicare provider in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) at the time the claim was processed or the ordering physician name was not submitted on the claim as entered in PECOS.

While these are only warning messages at this time, these claims will be denied when CMS implements Phase 2 of Change Request 6421; this date has not been established. Suppliers need to be proactive and use available tools (IVR, remittance advice message N544, and CMS listing) to research and ensure the ordering provider is enrolled in PECOS.

- N544: "Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future."

Below are resources suppliers can use to prepare for and prevent ordering-provider PECOS Phase 2 denials:

- The NAS IVR, 1-877-320-0390, Option 6, allows a supplier to enter the NPI and name of the referring provider. The IVR will then respond if the individual is or is not enrolled in PECOS.
- CMS ordering/referring provider downloadable report containing the NPI, first name, and last name of providers enrolled in PECOS, http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html.
- NAS webpage with educational resources regarding PECOS edit implementation, https://www.noridianmedicare.com/dme/news/pecos.html.

CMS has not released an implementation date for PECOS Phase 2 edits resulting in claim denials. Suppliers should be working with their referral sources when they are receiving Remark Code N544 on the remittance advice to ensure the provider has begun the process of enrolling in PECOS. Suppliers should also be using the IVR or CMS' downloadable reports to research new referral sources in order to confirm the provider is already in PECOS. Keep in mind that even if an ordering provider has an NPI, they may not be enrolled in PECOS. Suppliers have the responsibility to use the above tools to verify their ordering providers are enrolled in PECOS.

Suppliers should also ensure that they are entering the correct spelling of the ordering physician's name. Medicare compares the NPI and the first letter of the first name and the first four letters of the last name of the ordering/referring provider as reported on the claim to that same information in PECOS. It is important to ensure the name is in the correct order, does not contain "nicknames", and does not include credentials (i.e., "Dr.") when submitted.

Per MLN Matters Special Edition Article 1011, "Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/ Referring Provider's first name first, and last name second (e.g., John Smith)."

Narrative Required for Not Otherwise Classified HCPCS Codes

Suppliers are asked to include a concise description when billing Not Otherwise Classified (NOC) HCPCS Codes. This information is to be submitted within the Item 19 on the CMS-1500 claim form or the NTE segment in the 2400 loop (line level) for an electronic claim. The following listing of HCPCS has been provided to assist suppliers in proper claim and narrative submission when billing claims to NAS DME Jurisdiction D. Suppliers should remain current with HCPCS updates, Local Coverage Determinations, Policy Articles, CMS requirements, and other information regarding the DMEPOS they provide.

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

BILLING CONT'D

HCPCS	Modifiers	Short Description
J8499		Oral prescrip drug non chemo
J8597		Antiemetic drug oral NOS
J8999		Oral prescription drug chemo
J9999		Chemotherapy drug
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 NAS website, https://www.noridianmedicare.com/dme/claims/cms1500_08-05_instructions.html#19.

New IUR Process to Identify Previously Paid Claims for Services Furnished to Incarcerated Medicare Beneficiaries

MLN Matters® Number: MM8007
Related Change Request (CR) #: CR 8007
Related CR Release Date: November 1, 2012
Related CR Transmittal #: R1134OTN
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

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

What You Need to Know
This article is based on Change Request (CR) 8007, which informs Medicare contractors about the creation of a new Informational Unsolicited Response (IUR) process to identify and perform retroactive adjustments on any previously paid claims which may have been processed and paid erroneously during periods when the beneficiary data in the Enrollment Database (EDB) did not reflect the fact that the beneficiary was incarcerated.

Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated on the date of service that the items and services were furnished. Medicare is creating a new IUR process in its systems to identify previously paid claims that contain Dates of Service (DOS) that partially or fully overlap a period when the beneficiary was incarcerated (exceptions noted below). The IUR process will be initiated:

- When there is an automatic update to the beneficiary's record that indicates a change to the beneficiary's "incarcerated" start date or end date, or
- When there is a manual update to the beneficiary's record that indicates a change to the beneficiary's "incarcerated" start date or end date.

Upon receiving the IUR, Medicare contractors will initiate overpayment recovery procedures to recoup any Medicare **Part A and Part B payments.**

Background
Under Sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Accordingly, the Centers for Medicare & Medicaid Services (CMS) presumes that a State or local government entity that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of medical services and Medicare will generally not reimburse claims for services rendered to a beneficiary while he/she is in such custody.

Regulations at 42 Code of Federal Regulations (CFR) Section 411.4(b) state that:

> "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Federal benefit entitlement information is provided to CMS by the Social Security Administration (SSA) on a daily basis. When the SSA learns of a beneficiary's incarceration, the beneficiary's record in the EDB is updated to reflect that fact and the effective date (or "Start date") of the incarceration.

CMS Transmittal AB-02-164, CR2022, issued on November 8, 2002, implemented a Medicare systems edit to reject services billed to Medicare when information in the EDB indicates that, on the date of service, the beneficiary was incarcerated. Upon receipt of this rejection, Medicare contractors are instructed to deny the claims. CR4352, which manualized CR2022, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R883CP.pdf on the CMS website.

OIG Finding of Vulnerability
The Office of Inspector General (OIG) has recently identified a vulnerability where there may be, in some instances, a period of time between when the beneficiary is incarcerated and when the SSA learns of this status and updates its records (and Medicare files are subsequently updated). During this time, it is possible that Medicare Fee-For-Service (FFS) claims for services would be paid erroneously because the beneficiary's entitlement data in the EDB is not up-to-date when the claims are adjudicated.

Creation of IUR to Remedy Vulnerability
CMS has identified the IUR process as a means to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment.

Therefore, the intent of CR8007 is to create a new IUR process to identify and perform retroactive adjustments on any previously paid claims that may have been processed and paid erroneously during periods when the beneficiary data in the EDB did not reflect the fact that the beneficiary was incarcerated.

Additional Information
The official instruction, CR8007, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1134OTN.pdf on the CMS website.

New IUR Process to Identify Previously Paid Claims for Services Furnished to Medicare Beneficiaries Classified as "Unlawfully Present" in United States

MLN Matters® Number: MM8009
Related Change Request (CR) #: CR 8009
Related CR Release Date: November 1, 2012
Related CR Transmittal #: R1133OTN
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

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

What you Need to Know
This article is based on Change Request (CR) 8009, which informs Medicare contractors about the creation of a new Informational Unsolicited Response (IUR) process to identify and perform retroactive adjustments on any previously paid claims that contain dates of service (DOS) that partially or fully overlap a period when the beneficiary was unlawfully present in the United States. The IUR process shall be initiated:

- When there is an automatic update to the beneficiary's record in CWF via an EDB transaction which indicates a change to the beneficiary's "unlawfully present" start date or end date, or
- When there is a manual update to the beneficiary's record in CWF which indicates a change to the beneficiary's "unlawfully present" start date or end date.

Upon receiving the IUR, Medicare contractors will initiate overpayment recovery procedures to recoup any Medicare Part A and Part B payments.

Background
Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal benefits, including Medicare benefits. Consistent with this legislation, Section 10.1.4.8 of Chapter 1 of the "Medicare Claims Processing Manual" (http://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Downloads/clm104c01.pdf) states that: "Medicare payment may not be made for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service."

Federal benefit entitlement information is provided to the Centers for Medicare & Medicaid Services (CMS) by the Social Security Administration (SSA) on a daily basis. Such information is used in the adjudication of claims for healthcare services provided to Medicare beneficiaries. When the SSA learns of a beneficiary's status as "unlawfully present" in the United States, the beneficiary's record in Medicare's files is updated to reflect that fact and the effective date of that status.

CMS Transmittal AB-03-115, Change Request (CR) 2825, issued on August 1, 2003, implemented an edit in Medicare systems to reject services billed to Medicare when information in its files indicates that, on the date of service, the beneficiary was not lawfully present in the United States. Upon receipt of this rejection, Medicare contractors are instructed to deny the claim or claims.

OIG Finding of Vulnerability
The Office of Inspector General (OIG) has identified a vulnerability where there may be, in some instances, a period of time between when the beneficiary is deemed to be unlawfully present in the United States and when the SSA learns of this status and updates its records (and the Medicare files are subsequently updated). During this time, it's possible that Medicare Fee-For-Service (FFS) claims for services would be paid erroneously because the beneficiary's entitlement data is not up-to-date when the claims are adjudicated.

Creation of IUR to Remedy Vulnerability
CMS has identified a process to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment. Therefore, the intent of CR 8009 is to create a new process to identify and perform retroactive adjustments on any previously paid claims which may have been paid erroneously during periods when the beneficiary data in Medicare's files did not reflect the fact that the beneficiary was unlawfully present in the United States.

Additional Information
You can find the official instruction, CR8009, issued to your Medicare Carrier, FI, DME MAC, RHHI, or A/B MAC by visiting http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1133OTN.pdf on the CMS website.

Numerical Rounding Rules for Medicare

Recently several questions have arisen about how to handle reporting test results and determining coverage when the values are not whole numbers. This most often occurs for oxygen saturation results (either arterial blood gas or pulse oximetry) and sleep tests where the apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) results are expressed with a decimal place.

In both of these instances, standard numerical rounding rules apply. For example, consider a sleep test where the AHI is reported as below:

If the value is 12.01 to 12.49, round down to 12.
If the value is 12.50 to 12.99, round up to 13.

The only exceptions to this rule are where Medicare policy makes clear that the specified level is absolute and rounding is not to be used. One such situation is in the completion of Question 5 on the Oxygen Certificate of Medical Necessity ("Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a 'X'."). No rounding is allowed for flow rates less than 1.0.

Phase 2 of Ordering/Referring Requirement

MLN Matters® Number: SE1221 - Revised

Note: This article was revised on November 1, 2012, to replace a reference to the Social Security Act on page 2 with a reference to the Affordable Care Act. Also, on page 3, a clarification is made regarding the type of providers who may order/refer Portable X-Ray services. All other information remains the same.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,
- Part B providers (including Portable X-Ray services) and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A Home Health Agency (HHA) services who submit claims to RHHIs, Fiscal Intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Provider Action Needed
CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the Ordering/Referring Provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60 day advanced notice prior to turning on the Ordering/Referring edits. CMS does not have a date at this time.

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with Phase 2 Ordering/Referring edits. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background
The Affordable Care Act requires physicians or other eligible professionals to be enrolled in the Medicare Program to order/ refer items or services for Medicare beneficiaries. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI).

CMS began expanding the claims editing to meet these requirements for ordering and referring providers as follows:

> **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.
>
> Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),

- Physician Assistant,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,
- Interns, Residents, and Fellows

- Certified Nurse Midwife, and
- Clinical Social Worker.

The following exception is applicable for Part B services:

- Only Doctors of Medicine or Osteopathy may order/refer Portable X-Ray services.

The informational message will indicate that the identification of the Ordering/Referring provider is missing, incomplete, or invalid, or that the Ordering/Referring Provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

Note: if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

Phase 2: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 – This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code

37237 - This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," on April 24, 2012, permitting Phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement Phase 2 edits.

Additional Information
A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html, or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® fact sheet, "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf on the CMS website.

You may find the following articles helpful in understanding this matter:

- MLN Matters® Article MM6417, "Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf on the CMS website.
- MLN Matters® Article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf on the CMS website.
- MLN Matters® Article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)", is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf on the CMS website.
- MLN Matters® Article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf on the CMS website.
- MLN Matters® Article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf on the CMS website.

- MLN Matters® Special Edition Article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf on the CMS website.
- MLN Matters® Article Special Edition Article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf on the CMS website.
- MLN Matters® Special Edition Article SE1208, "855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals," is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf on the CMS website.

Update: Items Requiring Coding Verification Reviews by PDAC

Note: This article was updated to reflect the updated Effective Date of HCPCS code K0009.

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

The table below reflects the current list of HCPCS codes that require coding verification review by the PDAC along with the applicable LCD or Advisory Article for the code(s) and the date (i.e., claims with dates of service on or after) for when the requirement became effective.

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS		
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	4/1/2012
ENTERAL NUTRITION		
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G. GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G. GLUTAMINE, ARGININE), FAT (E.G. MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATION, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05

BILLING CONT'D

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
KNEE ORTHOTICS		
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/08
MANUAL WHEELCHAIR BASES		
K0009	OTHER MANUAL WHEELCHAIR/BASE	3/1/13
NEGATIVE PRESSURE WOUND THERAPY PUMPS		
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	1/1/06
OXYGEN AND OXYGEN EQUIPMENT		
E1405	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY	1/1/06
E1406	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY	1/1/06
PATIENT LIFT		
E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENT ACCESSIBLE CONTROLS	1/1/09
E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES	1/1/09
E0640	PATIENT LIFT, FIXED SYSTEM, INCLUDES ALL COMPONENTS/ACCESSORIES	1/1/09
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	1/1/09
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS	1/1/09
PNUEMATIC COMPRESSION DEVICES		
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL	1/1/06
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE	1/1/06
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE	1/1/06
POWER MOBILITY DEVICES		
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06

BILLING CONT'D

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	11/15/06
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE	11/15/06
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS	11/15/06
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06

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K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	11/15/06
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	11/15/06
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	11/15/06
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	11/15/06
K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA	11/15/06
PRESSURE REDUCING SUPPORT SURFACES - GROUP 2		
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	1/1/06
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS	1/1/06
SPINAL ORTHOSES: TLSO and LSO		
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION	8/31/11
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTEVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0452	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, CUSTOM FABRICATED	7/1/10
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

BILLING CONT'D

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0458	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0462	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0464	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, FOUR RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

BILLING CONT'D

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0470	TLSO, TRIPLANAR CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO SCAPULA, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, ROTATIONAL STRENGTH PROVIDED BY SUBCLAVICULAR EXTENSIONS, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANVERSE PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0472	TLSO, TRIPLANAR CONTROL, HYPEREXTENSION, RIGID ANTERIOR AND LATERAL FRAME EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH WITH TWO ANTERIOR COMPONENTS (ONE PUBIC AND ONE STERNAL), POSTERIOR AND LATERAL PADS WITH STRAPS AND CLOSURES, LIMITS SPINAL FLEXION, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0480	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0482	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0484	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0486	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0488	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

BILLING CONT'D

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0490	TLSO, SAGITTAL-CORONAL CONTROL, ONE PIECE RIGID PLASTIC SHELL, WITH OVERLAPPING REINFORCED ANTERIOR, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES AT OR BEFORE THE T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XIPHOID, ANTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL AND CORONAL PLANES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0491	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0492	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0629	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10

BILLING CONT'D

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0632	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0634	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0635	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANEL(S), LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0636	LUMBAR SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANELS, LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10

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L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0638	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0640	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
SURGICAL DRESSINGS		
A6545	GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH	1/1/09
THERAPEUTIC SHOES FOR PERSONS WITH DIABETES		
A5512	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH	1/1/06
A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH	1/1/06
WALKERS		
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE	1/1/06
WHEELCHAIR SEATING		
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2605	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2606	POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2607	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2608	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION, ANY SIZE	7/1/04
E2610	WHEELCHAIR SEAT CUSHION, POWERED	7/1/04
E2611	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2612	GENERAL USE WHEELCHAIR BACK CUSHION, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2613	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2614	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2615	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2616	POSITIONING WHEELCHAIR BACK CUSHION, POSTERIOR-LATERAL, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2617	CUSTOM FABRICATED WHEELCHAIR BACK CUSHION, ANY SIZE, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2620	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH LESS THAN 22 INCHES, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2621	POSITIONING WHEELCHAIR BACK CUSHION, PLANAR BACK WITH LATERAL SUPPORTS, WIDTH 22 INCHES OR GREATER, ANY HEIGHT, INCLUDING ANY TYPE MOUNTING HARDWARE	7/1/04
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04

The PDAC coding verification applications required for these products are located on the PDAC website at: https://www.dmepdac.com/review/apps_check.html.

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

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.

DME CERT Task Force Presentation Now Available!

The DME CERT Task Force, a multi-jurisdictional group from the four DME MACs, collaborates to educate our supplier community on various ways to decrease the CERT error rate.

This Task Force conducted a webinar presentation on July 24, 2012, that outlined four aspects of Medicare's documentation requirements, including

- Orders
- Continued Use/ Need
- Request for Refill
- Proof of Delivery

This presentation has been posted to our website so you can review the slides and the information discussed during the webinar. Please click the following link to access the presentation: https://www.noridianmedicare.com/dme/train/presentations/cert_taskforce.pdf [PDF]

COMPETITIVE BIDDING

CMS Announces Timeline for DMEPOS Competitive Bidding Round 1 Recompete; Begins Bidder Education Program

Bidding Timeline
CMS has announced the bidding timeline for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. To view the timeline, visit the Competitive Bidding Implementation Contractor (CBIC) website at www.dmecompetitivebid.com.

Bidder Education Program
CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner. The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC web site features a comprehensive array of important information for suppliers, including bidding rules, user guides, policy fact sheets, checklists, and bidding information charts. The education program will also include webcasts that will cover all the essential topics suppliers will need to know in order to bid. These webcasts will be posted on the CBIC web site and will be available 24 hours a day/7 days a week. When a webcast is posted, the CBIC will announce its availability through a CBIC email update announcement. To sign up to receive webcast announcements and other key registration and bidding information, visit the CBIC web site and subscribe to email updates.

In addition to viewing the information on the CBIC website, DMEPOS suppliers are encouraged to call the CBIC toll-free help desk, 877-577-5331, with their questions and concerns.

DME National Competitive Bidding: National Mail Order Program Implementation for Diabetic Supplies

MLN Matters® Number: MM8080 Revised
Related Change Request (CR) #: 8080
Related CR Release Date: November 1, 2012
Related CR Transmittal #: R1139OTN
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: This article was revised on November 6, 2012 to remove the words “and accept” from the second paragraph on page 2. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for Medicare Durable Medical Equipment , Prosthetics, Orthotics, & Supplies (DMEPOS) suppliers that submit claims for Medicare payment to Durable Medical Equipment (DME) Medicare Administrative Contractors (DME MACs) for diabetic supplies delivered to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 8080 and reminds suppliers that, effective July 1, 2013, Medicare Part B payment for covered diabetic testing supplies delivered to a Medicare beneficiary’ s home by any method is subject to the NMO Competitive Bidding Program. This program applies throughout the United States with the exception of the Northern Mariana Islands.

Once the program goes into effect, beneficiaries with Original Medicare who get diabetic testing supplies delivered to their homes will have to use a Medicare contract supplier in order for Medicare to make payment unless an exception applies. Suppliers that are awarded an NMO contract will be required to furnish mail order diabetic testing supplies to beneficiaries with Original Medicare in all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa. Beneficiaries residing in the Northern Mariana Islands are not included in the NMO program.

Key Points

- Beneficiaries may choose to pick up diabetic testing supplies in person from retail pharmacy locations or other local supplier storefronts or have them delivered to their homes. Once the program is implemented, only NMO contract suppliers will be reimbursed by Medicare Part B for providing diabetic testing supplies delivered to beneficiaries’ residences. If the supplies are shipped or delivered by any means to the beneficiary’s home, then the supplier that furnished the supplies must be a NMO contract supplier for Medicare to pay.

- The only diabetic testing supplies not included in the program are those that are obtained directly by a beneficiary or caregiver by physically going to an enrolled DMEPOS supplier storefront and leaving the store with the diabetic testing supplies.
- The only supplier that can bill for these non mail-order diabetic supplies is the supplier from which the beneficiary or caregiver physically picked up the supplies. Diabetic supplies furnished by any means other than mail-order or pickup are not payable by Medicare.
- The term "mail-order" means items shipped or delivered to the beneficiary's residence by any method.
- All suppliers are required to use the KL modifier on each claim for diabetic supplies furnished on a mail-order basis. Suppliers that furnish diabetic testing supplies on a mail-order basis that do not attach the mail-order modifier could be subject to significant penalties.
- Claim lines for items subject to the NMO program for diabetic supplies provided by a non-contract supplier on or after July 1, 2013 will be denied, For paid claim lines where the submitted charge exceeds the single payment amount in the contract, the remittance will be the single payment amount. Contract suppliers must accept assignment for items in their contracts.

Background
CR 8080 provides guidance for systems changes in preparation for NMO program implementation. Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new competitive bidding program (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 the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

The Medicare Improvements for Patients and Providers Act (MIPPA) authorized competition for national mail order items and services after 2010.

Additional Information
The official instruction, CR 8080 issued to your DME MAC regarding this change, may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1139OTN.pdf on the CMS website.

Providers may find more detailed information about the competitive bidding program at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/ on the CMS website.

DOCUMENTATION

Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment

MLN Matters® Number: SE1238

Provider Types Affected
This MLN Matters® Special Edition (SE) Article is intended for providers and suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

What You Need to Know
This article highlights the April 2012 report from the Office of the Inspector General (OIG) titled "Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment." The article also focuses on the Medicare policy regarding the required documentation suppliers must have on file.

The objective of this OIG study was to determine whether the KX modifier was effective in ensuring that DMEPOS suppliers who submitted Medicare claims had the required supporting documentation on file. The study included individual reviews of the four contractors that processed the DMEPOS claims for Jurisdictions A through D with dates of service in 2007.

The OIG report focused on the following four categories of DMEPOS claims containing the KX modifier for Calendar Year (CY) 2007:

1. therapeutic shoes for diabetics,
2. continuous positive airway pressure systems,
3. respiratory assist devices, and
4. pressure reducing support surfaces (groups 1 and 2).

Background
Medicare providers and suppliers have a vital role in helping the Centers for Medicare & Medicaid Services (CMS) effectively manage Medicare resources. CMS acknowledges the daily challenges providers and suppliers face in serving Medicare beneficiaries and the complex process involved in obtaining and receiving the required documentation.

For certain DMEPOS, suppliers must use the KX modifier. The KX modifier indicates that the claim meets Medicare coverage criteria and the supplier has the required documentation on file. While suppliers must have a written physician's order and proof of delivery for all DMEPOS, suppliers must have additional documentation on file for items requiring the KX modifier. For example, therapeutic shoes also require that a certifying physician's statement be on file before the supplier bills Medicare.

OIG Findings
The report found that in CY 2007:

1. 60% of the sampled 400 claims, suppliers did not have the required documentation on file;
2. 37% of the claims were missing the physician orders;
3. 21% were missing proof of delivery;
4. 25% were missing use or complaint use follow-up statements; and
5. 2% were missing sleep studies.

The Key Points section below reviews Medicare policy for coverage of therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2). Each DMEPOS has similar requirements that will be listed first. For additional document requirements, each DMEPOS will be listed thereafter.

Key Points
CMS reminds physicians that in order for these items to be reimbursed for their patients, the DME supplier must collect medical documentation. This includes copies of the initial evaluation and any other reports needed to comply with coverage criteria specific to:

1. therapeutic shoes for diabetics;
2. continuous positive airway pressure systems;
3. respiratory assist devices; and
4. pressure reducing support surfaces (groups 1 and 2).

Cooperation and coordination between physicians and suppliers is necessary to meet Medicare coverage documentation requirements and deliver effective and efficient healthcare to beneficiaries.

The Local Coverage Determinations (LCDs) for all four DME MACs require suppliers to have the same documentation on file for the categories of DMEPOS and dates of service included in this OIG audit. Additional coverage and payment rules for therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2) may be found in the LCDs for the applicable DME MAC. **See the Additional Information section below to find websites for all four contractors.**

The complete medical policy is posted on individual DME MAC websites, or in the CMS Medicare Coverage Database. The database is available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website. Each category of DMEPOS in this study requires the following documentation:

DOCUMENTATION CONT'D

1. Valid written order that contains:
   - Beneficiary's name;
   - Treating physician's signature;
   - Date the treating physician signed the order, and
   - Start date of the order.
2. Proof of delivery.

Additional documentation requirements for each category of DMEPOS are also listed as follows:

Therapeutic Shoes

1. Signed statement from the certifying physician (must be MD or DO) who is treating the patient's systemic diabetes condition;
   - Patient has diabetes mellitus; and
   - Patient has one of the following:
     a. Previous amputation of the other foot, or part of either foot; or
     b. History of previous foot ulceration of either foot; or
     c. History of pre-ulcerative calluses of either foot; or
     d. Peripheral neuropathy with evidence of callus formation of either foot; or
     e. Foot deformity of either foot; or
     f. Poor circulation in either foot.

Certify that the above two indications are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes; and the patient needs diabetic shoes.

2. Documentation of an in-person evaluation of the patient by the certifying physician who is managing the patient's systemic diabetes condition within 6 months specifying:
   a. The patient has diabetes mellitus;
   b. Has one of the conditions 2a-2f listed in Policy Article A37076;
   c. Is being treated under a comprehensive plan of care for his/her diabetes, and
   d. Requires diabetic shoes.
3. Documentation of an in-person evaluation of the patient by the supplier prior to selection of the items billed that included:
   a. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
   b. For all shoes, taking measurements of the patient's feet.
   c. For custom molded shoes and inserts, 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.
4. Medical records supporting that the patient has diabetes mellitus and at least one of the conditions noted above.
5. Documentation of an in-person visit with the patient by the supplier at the time of delivery must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

Note: Please refer to the basic coverage criteria specified in the Therapeutic Shoes LCD for your DME MAC for further guidance.

Continuous Positive Airway Pressure Systems

1. Documentation of a verbal order (if item is dispensed based on a verbal order) that contains:
   b. Description of the item;

DOCUMENTATION CONT'D

c. Name of the beneficiary;

d. Name of the physician, and

e. Start date of the order

2. Valid written order that contains:

a. Beneficiary's name

b. Treating physician's signature

c. Date the treating physician signed the order

d. Start date of the order-if the start date differs from the signature date.

e. Order for PAP with pressure setting.

3. Beneficiary Authorization.

4. Proof of Delivery.

5. Face-to-Face clinical evaluation by the physician prior to the sleep test to assess the patient for obstructive sleep apnea (OSA) containing the following elements:

a. Sleep history and symptoms which may be caused by OSA;

b. Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory, and

c. Pertinent physical examination – e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam.

6. Medicare-covered sleep test that meets either of the following criteria:

a. Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to15 events per hour with a minimum of 30 events; OR

b. AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:

i. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, OR

ii. Hypertension, ischemic heart disease, or history of stroke.

7. Documentation that the patient and/or caregiver received instruction from the supplier of the Positive Airway Pressure (PAP) device and accessories in the proper use and care of the equipment.

8. To continue coverage for the PAP device (Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD)) beyond an initial 3-month trial period, there must be:

a. A face-to-face visit with the physician during the second or third month of the trial that documents an improvement of the beneficiary's symptoms; and

b. A data report from the PAP device which documents use of the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

9. For beneficiaries who received a PAP device prior to Fee-For-Service (FFS) Medicare enrollment and are now enrolled in Medicare and are seeking a new PAP device and/or accessories, both of the following coverage requirements must be met:

a. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories, and,

b. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:

i. The beneficiary has a diagnosis of obstructive sleep apnea; and,

ii.. The beneficiary continues to use the PAP device.

DOCUMENTATION CONT'D

Note: Please refer to the basic coverage criteria specified in the PAP LCD by your DME MAC contractor for further guidance.

Respiratory Assist Devices

1. Documentation of a verbal order (if item is dispensed based on a verbal order) that contains:
   a. Description of the item;
   b. Name of the beneficiary;
   c. Name of the physician, and
   d. Start date of the order.
2. Valid written order that contains:
   a. Beneficiary's name
   b. Item to be dispensed
   c. Pressure setting with or without backup rate
   d. Treating physician's signature
   e. Date the treating physician signed the order
   f. Start date of the order if the start date differs from the signature date.
3. Beneficiary Authorization.
4. Proof of Delivery.
5. Medical records documenting:
   a. Symptoms characteristic of sleep-associated hypoventilation.
   b. Patient has one of the following disorders and meets all coverage criteria for that disorder:
      i. Restrictive Thoracic Disorder, or
      ii.. Severe COPD, or
      iii. Central Sleep or Complex Sleep Apnea, or
      iv. Hypoventilation Syndrome.

Note: Please refer to the basic coverage criteria specified in the RAD LCD by your DME MAC contractor for further guidance.

Pressure Reducing Support Surfaces (groups 1 and 2).

1. Valid written order that contains:
   a. Beneficiary's name
   b. Treating physician's signature
   c. Date the treating physician signed the order
   d. Start date of the order if the start date differs from the signature date.
   e. Clear, detailed description of the type of support surface the physician is ordering.
2. Beneficiary Authorization.
3. Signed statement from the treating physician indicating what, if any, payment criteria the patient meets.
4. Medical records supporting patient meets the basic coverage criteria specified in the Pressure Reducing Support Surfaces- Group 1 and 2 LCD.

Note: Please refer to the basic coverage criteria specified in the Pressure Reducing Support Surfaces- Group 1 and 2 LCDs by your DME MAC contractor for further guidance.

Additional Information

The OIG report titled "Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment" is available at http://oig.hhs.gov/oas/reports/region4/41004004.pdf on the OIG website.

The Medicare Learning Network® (MLN) fact sheet titled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf on the CMS website.

The DME MAC websites are available as follows:

- Cigna Government Services
- National Government Services
- National Heritage Insurance Company (NHIC)
- Noridian Administrative Services

Ordering and Certifying Documentation - Maintenance Requirements

MLN Matters® Number: MM7890
Related Change Request (CR) #: CR 7890
Related CR Release Date: August 31, 2012
Related CR Transmittal #: R431PI
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected
This MLN Matters® Article is intended for physicians, non-physician practitioners, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers and Home Health Agencies (HHAs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

Provider Action Needed
This article, based on Change Request (CR) 7890, informs you of instructions to Medicare contractors regarding the implementation of ordering and certifying documentation and maintenance requirements found in 42 Code of Federal Regulations (CFR) 424.516(f).

- A provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to:
- Maintain documentation for 7 years from the date of service, and

Provide access to that documentation upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor.

A physician who orders/certifies home health services and a physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to:

- Maintain the documentation for 7 years from the date of service, and
- Provide access to that documentation upon the request of CMS or a Medicare contractor.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

Review the description of documentation to be maintained in the Background section below. Make sure that your billing staffs are aware of these requirements for documentation.

Background
Under 42 CFR 424.516(f)(1), a provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to (1) maintain documentation (see next paragraph) for 7 years from the date of service, and (2) provide access to that documentation

upon the request of CMS or a Medicare contractor.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

In addition, under 424.516(f)(2), a physician who orders/certifies home health services and the physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician, or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

The CMS policy states that, absent a CMS directive to the contrary, the Medicare contractor will request the documentation described above if it has reason to believe that the provider, supplier, physician or eligible professional (hereinafter collectively referred to as "provider") is not maintaining the documentation in accordance with Section 424.516(f)(1) or (2).

Examples of when a request might be appropriate include, but are not limited to, the following:

The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has otherwise generated an alert with respect to the provider.

- The provider has been the subject of a recent Zone Program Integrity Contractor referral.
- The provider maintains an elevated surety bond amount.
- If a provider fails to respond to a letter request for documentation within 30 days of the Medicare contractor's request, the contractor may revoke the provider's Medicare billing privileges and impose a 1-year re-enrollment bar.

Additional Information
The official instruction, CR7890 issued to your carrier, FI, or A/B MAC regarding this change may be viewed http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R431PI.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

DRUGS/BIOLOGICALS

October 2012 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Number: MM7885
Related Change Request (CR) #: CR 7885
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R2514CP
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable

Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed
Medicare will use the October 2012 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2012, with dates of service from October 1, 2012, through December 31, 2012.

Change Request (CR) 7885, from which this article is taken, instructs your Medicare contractors to download and implement the October 2012 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised July 2012, April 2012, January 2012, and October 2011 files.

Background
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 for Dates of Service
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2012

Additional Information
You can find the official instruction, Change Request (CR) 7885, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/downloads/R2514CP.pdf on the CMS website.

Widespread Prepayment Review for Immunosuppressive Drugs – Edit Effectiveness for Fourth Quarter

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

The results of the review, for item J7507, identified 2,637 claims of which 2,397 were denied. A total of 1,664 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 90%.

The result of the review, for item J7517, identified 1,689 claims of which 1,513 were denied. A total of 1,053 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 90%.

The result of the review, for item J7518, identified 676 claims of which 626 were denied. A total of 418 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 93%.

The result of the review, for item J7520, identified 246 claims of which 228 were denied. A total of 149 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 94%.

The following are the top reasons for denial:

a. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

b. No refill request documentation provided

c. No proof of delivery

d. Date on the proof of delivery does not match the date of service

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

a. A large number of suppliers failed to respond to our request for records.

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

b. For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill. For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

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

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

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

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Immunosuppressive Drugs Local Coverage Determination (LCD) L68 and Policy Article A25366. Suppliers can also review the Immunosuppressive Drugs documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html.

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

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

MLN Matters® Number: MM8116
Related Change Request (CR) #: CR 8116
Related CR Release Date: October 26, 2012
Related CR Transmittal #: R2568CP
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

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

Provider Action Needed
Medicare will use the January 2013 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2013, with dates of service from January 1, 2013, through March 31, 2013.

DRUGS/BIOLOGICALS CONT'D

Change Request (CR) 8116, from which this article is taken, instructs your Medicare Contractors to download and implement the January 2013 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2013, October 2012, July 2012, April 2012, and January 2012 files.

Background
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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website.)

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

Files	Effective for Dates of Service
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
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April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012

Additional Information
You can find the official instruction, CR8116, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/downloads/R2568CP.pdf on the CMS website.

EDUCATIONAL

CMS e-News

Per CMS TDL 12528, the e-News pilot directives provided in CMS TDL 12438, effective through September 30, 2012, has been extended until further notice. This brief article contains a link to the CMS publication e-News – a Medicare Learning Network® product. This link contains a week's worth of Medicare-related topics for Medicare Fee-for-Service (FFS) providers/suppliers and is a new approach to improve consistency and to streamline operations in messaging the provider community across all Medicare information channels.

August 15, 2012 Edition
Calls, Meetings, and Events

- Special Open Door Forum Series: IRF Quality Reporting Program
- August 16 Special Open Door Forum for Long-Term Care Hospital Providers - Rescheduled for August 30

Announcements and Reminders

- Major Improvements to the Internet-based PECOS System
- Have You Tried the CMS Medicare Physician Fee Schedule Search Tool?
- CMS to Release a Comparative Billing Report on Podiatry Services - Target Release September 13
- Summary of Findings from 2011 ESRD Monitoring Now Available
- IRF-PAI Validation Utility Tool Now Available
- Get Ready for DMEPOS Competitive Bidding

Claims, Pricer, and Code Updates

- HIPAA 5010 837 Professional Crossover Claims Issue Tied to Edits H10658 and H20658

MLN Educational Products Update

- "Quick Reference Information: Medicare Immunization Billing" Educational Tool - Revised

- "Medicaid Program Integrity: Safeguarding Your Medical Identity" Educational Products - Released
- Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS)" MLN Matters® Article - Released
- "Important Update Regarding 5010/D.0 Implementation - Action Needed Now" MLN Matters® Article - Reminder
- New MLN Provider Compliance Fast Fact
- Be Part of the MLN Creative Process - Volunteer Now

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-15Enews.pdf

August 22, 2012 Edition
National Provider Calls

- Medicare Shared Savings Program Application Process Question and Answer Session - Register Now
- Audio Recording and Written Transcript from July 31 Medicare Shared Savings Program and Advance Payment Model Application Process Call Now Available

Announcements and Reminders

- 2012 Physician Quality Reporting System Program Reminder
- CMS Continues Efforts to Improve Quality of Care for People with Medicare
- CMS Announces Primary Care Practices to Participate in Historic Public-Private Partnership to Strengthen Primary Care
- People with Medicare Save Over $4.1 Billion on Prescription Drugs Thanks to the Health Care Law
- Long Term Care Hospital Technical Trainings related to the LTCH CARE Data Submission and LASER Available for Download
- Develop Your ICD-10 Communication and Awareness Plan
- Act Now to Avoid Claim Denials for Ordered/Referred Services
- All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer

Claims, Pricer, and Code Updates

- CY 2012 Home Health Prospective Payment System PC Pricer has been Updated
- Inpatient Prospective Payment System PC Pricer Updated
- January 2013 Edit Spreadsheet Changes

MLN Educational Products Update

- August 2012 Version of Medicare Learning Network® Products Catalog Now Available
- "Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS)" MLN Matters® Article - Released
- New Enhancements to the MLN Product Ordering System
- New Continuing Education Association Now Accepting Medicare Learning Network® (MLN) Courses
- "CMS Website Wheel" Educational Tool - Reminder
- "Medicaid Program Integrity: Safeguarding Your Medical Identity" Educational Products - Released

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-22e-News.pdf

August 29, 2012 Edition
National Provider Calls

- Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs - Registration Now Open
- Audio Recording and Written Transcript from August 15 Five New Medicare Preventive Services Call Now Available

Other Calls, Meetings, and Events

- Special Open Door Forum: Long Term Care Hospitals

Announcement and Reminders

- HHS Announces Next Steps to Promote Use of Electronic Health Records and Health Information Exchange
- Visit the New Stage 2 Web Page on the EHR Incentive Programs Website
- Now Available: Stage 2 Overview Tipsheet
- New Health Care Standards to Save up to $6 Billion
- HHS Secretary Kathleen Sebelius Announces Compliance Date for ICD-10
- Now Available: New Webcast for Round 1 Recompete Bidders
- Inpatient Rehabilitation Facilities: Important Announcements

Claims, Pricer, and Code Updates

- Inpatient Psychiatric Facility Prospective Payment System FY2012 Pricer File Update

MLN Educational Products Update

- "Important Reminder About Medicare Secondary Payer Laws" MLN Matters® Article - Released
- "Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)" MLN Matters® Article - Released
- "Hospice Payment System" Fact Sheet - Revised

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-29-e-News.pdf

September 13, 2012 Edition
National Provider Calls

- Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs - Register Now
- Physician Quality Reporting System and Electronic Prescribing Incentive Program - Registration Now Open
- Hospital Value-Based Purchasing: FY 2013 Actual Percentage Payment Summary Report - Registration Now Open
- Audio Recording and Written Transcript from August 23 Medicare Shared Savings Program Application Process Question and Answer Session Call Now Available

Other Calls, Meetings, and Events

- IRF Quality Reporting Program Special Open Door Forum Series

Announcements and Reminders

- September is Prostate Cancer Awareness Month
- DMEPOS Suppliers Must Use Individual Practitioner NPIs to Bill for Ordered/Referred Services
- Recorded Training Sessions Available for IRFs
- FY 2013 ICD-10-PCS Reference Manual and Coding Guidelines Now Available
- 5010 Remittance Advice (835) Companion Guide Update
- Updates to IRIS Software
- Updated Physician Payment Information for Value-Driven Health Care Now Available
- Time is Running Out for Authorized Officials to Register for DMEPOS Competitive Bidding

Claims, Pricer, and Cope Updates

- October 2012 Average Sales Price Files Now Available
- Correct Coding Initiative Edit Files Configuration Change

MLN Educational Products Update

- "Clarification of the Quality Standards and Accreditation Requirements for Ultra Lightweight Manual Wheelchairs" MLN Matters® Article - Released
- "Providing the Annual Wellness Visit (AWV)" Booklet - Released
- "Cardiovascular Disease Services" Booklet - Released
- "Screening Pap Tests Services" Booklet - Released

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-12-e-News.pdf

September 19, 2012 Edition
National Provider Calls

- Physician Quality Reporting System and Electronic Prescribing Incentive Program - Register Now
- Hospital Value-Based Purchasing: FY 2013 Actual Percentage Payment Summary Report - Register Now
- Video Slideshow Presentation and Podcasts from July 31 National Provider Call on the Medicare Shared Savings Program and Advance Payment Model Application Process Now Available

Announcements and Reminders

- Influenza Season is Around the Corner
- Quality Reporting Program Announcements for ASCs
- Long-Term Care Hospital Announcements and Updates
- IRF-PAI Submission System Downtime September 29-30
- jIRVEN and Training Announcements for IRFs
- ICD-10 Transition Information Providers and Payers Need to Share
- CMS/ONC Blog Post Celebrates Meaningful Use Day of National Health IT Week; Discusses Importance of Meaningful Use

Claims, Pricer, and Code Updates

- Information about a Medicare Claims Processing Issue Related to Part B Services for Skilled Nursing Facility Patients

MLN Educational Products Update

- "Hospital Reclassifications" Fact Sheet - Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet - Revised
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" Booklet - Reminder
- "The Basics of DMEPOS Accreditation" Fact Sheet - Reminder
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet - Reminder
- "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders" Podcast Released
- "Documenting Medical Necessity for Major Joint Replacement (Hip and Knee)" MLN Matters® Article Released
- "Important Information Concerning the Medicare Crossover Process and State Medicaid Agency Requirements for National Drug Codes (NDCs) Associated with Physician-Administered Part B Drugs" MLN Matters® Article Released

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-19-e-News.pdf

September 26, 2012 Edition
National Provider Calls

- Hospital Value-Based Purchasing: FY 2013 Actual Percentage Payment Summary Report - Register Now
- Medicare Provider Enrollment: Updates on Revalidation, Billing for Ordered/Referred Services and PECOS Enhancements - Registration Now Open

Announcements and Reminders

- One World, One Home, One Heart - World Heart Day
- October 3 is the Last Day for EPs to begin 90-day reporting period for the Medicare EHR Incentive Program
- Updated Hospital Outpatient Payment Information for Value-Driven Health Care Now Available
- Now Available: New Webcast for Round 1 Recompete Bidders
- Time is Running Out to Register for DMEPOS Competitive Bidding

Claims, Pricer, and Code Updates

- Correct Coding Initiative Edit Files Configuration Change
- IRF Claims Processing Issue

MLN Educational Products Update

- "Communicating With Your Medicare Patients" Fact Sheet - Released
- "Section 1011: Federal Reimbursement of Emergency Health Services to Undocumented Aliens" Fact Sheet - Revised
- "Inpatient Rehabilitation Services: Complying with Documentation Requirements" Fact Sheet - Revised
- "Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment" MLN Matters® Article - Released
- "Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article - Revised
- "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" MLN Matters® Article - Revised
- "Phase 2 of Ordering/Referring Requirement" MLN Matters® Article - Revised
- New MLN Provider Compliance Fast Fact
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-26-e-News.pdf

October 4, 2012 Edition
National Provider Calls

- Medicare Provider Enrollment: Updates on Revalidation, Billing for Ordered/Referred Services, and PECOS Enhancements - Register Now
- In-depth Overview of Stage 2 Clinical Quality Measures for the Medicare and Medicaid EHR Incentive Programs for Eligible Professionals - Save the Date
- Preparing Physicians for ICD-10 Implementation - Registration Now Open
- Transcript and Audio Now Available From September 13 Call on Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs

Announcements and Reminders

- Vaccination is the Best Protection Against the Flu
- New Program to Increase Quality in Nursing Facilities
- 2011 Electronic Prescribing (eRx) Incentive Program Feedback Reports are Now Available

- Preliminary Decisions on the Recommendations of the Hospital Outpatient Payment Panel - Comments Due October 24
- Materials from the ICD-9-CM Coordination and Maintenance Committee Now Available
- Now Available: New Email Updates for Those Who Refer Medicare Beneficiaries for DMEPOS

Claims, Pricer, and Code Updates

- October 2012 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products Update

- "Screening and Diagnostic Mammography" Booklet - New
- "Complying with Medicare Signature Requirements" Fact Sheet - Revised
- "Updated ICD-10 Implementation Information" MLN Matters® Article Released
- "Partial Code Freeze Prior to ICD-10 Implementation" MLN Matters® Article Released
- Submit Feedback on MLN Educational Products

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-04-e-News.pdf

October 11, 2012 Edition
National Provider Calls

- In-depth Overview of Stage 2 Clinical Quality Measures for the Medicare and Medicaid EHR Incentive Programs for Eligible Professionals - Registration Now Open
- Preparing Physicians for ICD-10 Implementation - Register Now

Other Calls, Meetings, and Events

- Special Open Door Forum Series: IRF Quality Reporting Program

Announcements and Reminders

- CMS Recognizes October as National Breast Cancer Awareness Month
- Vaccination is the Best Protection Against the Flu - Influenza Vaccine Prices Are Now Available
- The ICD-10 Planning Checklist
- New Process for Beneficiary Name/Number Mismatches

MLN Educational Products Update

- "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" Educational Tool - Revised
- "Advance Beneficiary Notice of Noncoverage Part A and Part B" Booklet - Revised
- "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet - Revised

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-11-e-News.pdf

October 18, 2012 Edition
Announcements and Reminders

- Last Day to Register for the Round 1 Recompete of the DMEPOS Competitive Bidding Program is Friday, October 19, 2012
- Major Improvements to the Internet-based PECOS System
- Latest Version of MREP for Medicare FFS Professional Providers and Suppliers

MLN Educational Products Update

- Medicare Quarterly Provider Compliance Newsletter (Volume 3, Issue 1) Educational Tool — Released
- New MLN Provider Compliance Fast Fact

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-18-e-News.pdf.

October 25, 2012 Edition
National Provider Calls

- Transcript and Audio Now Available from October 10 Call on Medicare Enrollment: Updates on Revalidation, Billing for Ordered/Referred Services and PECOS Enhancements

Announcements and Reminders

- CMS Releases Corrections Document for Stage 2 Meaningful Use Final Rule
- October 29 Deadline for Hospitals to Apply for Additional IME and Direct GME FTE Cap Slots Under Round 3 of Section 5506 of the Affordable Care Act

Claims, Pricer, and Code Updates

- Quarterly Provider Specific Files for the Prospective Payment System are Now Available

MLN Educational Products Update

- "Medicare Claim Submission Guidelines" Fact Sheet - Released
- "Screening and Diagnostic Mammography" Booklet - New
- "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" Booklet - New
- "Intensive Behavioral Therapy (IBT) for Obesity" Booklet - New
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" PowerPoint and Facilitator Kit - Released
- "A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter" MLN Matters® Article - Reminder

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-25-e-News.pdf

November 1, 2012 Edition
National Provider Calls

- Video Slideshow Presentation and Podcasts from August 15 Call on the Five New Medicare Preventive Services Now Available

Announcements and Reminders

- CMS Posts 2014 Clinical Quality Measures, Electronic Specifications and Resources on Website
- Read Our New FAQ Discussing Hospital Payment Calculations for the Medicaid EHR Incentive Program
- How to Get Your Practice Ready for the ICD-10 Transition
- Modifications to the HCPCS Code Set Available

Claims, Pricer, and Code Updates

- Delay in 2013 PC Pricers for Claims Effective October 1, 2012
- Billing Instructions for Suppliers that Wish to Obtain a Medicare Denial for Non-Covered Codes Subject to ESRD PPS Consolidated Billing Requirements

MLN Educational Products Update

- "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC" Booklet - Revised
- "Screening for Depression" Booklet
- "Screening Pelvic Examinations" Booklet - Released
- "Medicare Guidance Regarding Meningitis Outbreak" MLN Matters® Article - Released
- Opportunity for Medicare Learning Network® Pilot Testers and Product Reviewers

Select the following link to access the entire e-News publication: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-01-e-News.pdf

November 8, 2012 Edition
National Provider Calls

- Physician Quality Reporting System and Electronic Prescribing Incentive Program - Registration Now Open

Announcements and Reminders

- Diabetes and the Seasonal Flu
- November is National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day on November 14
- Important Update on 2013 Electronic Prescribing Payment Adjustment Hardship Exemptions
- 2011 PQRS Feedback Reports and Informal Review Now Available
- WebEx Training on Hospice Quality Reporting Program Data Entry and Submission Available November 12
- CMS Medical Identity Theft Web-Based Training Course for Providers Available
- ICD-10: Working with Your Software Vendor
- Read Our Two New FAQs Providing Information on the Stage 2 Meaningful Use Transitions of Care Measure

Claims, Pricer, and Code Updates

- Acute Inpatient PPS FY 2013 Mainframe Software Available
- CY 2012 Outpatient Prospective Payment System Pricer File Update
- MLN Educational Products Update
- Quick Reference Information Resources: Medicare Preventive Services - Revised
- "Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Medicare Fee-For-Service (FFS) Providers Informed" Fact Sheet - Revised
- "Phase 2 of Ordering/Referring Requirement" MLN Matters® Article - Revised

NAS Ask the Contractor Teleconference Questions and Answers - July 19, 2012

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

Endeavor
Endeavor was enhanced to offer overpayment information based on the Financial Control Number (FCN) displayed on your remittance advice. Additionally, Endeavor offers registered users access to eligibility, claim status, same or similar equipment, appeal submission, appeal status inquiries, and claim-specific remittance advice inquiries. Suppliers are encouraged to register for our free supplier portal, Endeavor, by accessing the claims portion of our website. Endeavor-issued user IDs cannot be used by more than one person.

Email Updates
If suppliers are not already signed up for our e-mail updates we strongly encourage everyone to do so. NAS sends e-mails every Tuesday and Friday containing the latest updates, news, workshop announcements, and much more. To sign up, go to our website and click on E-Mail Newsletter and sign up on the left hand side of our website.

Fax Submission Reminders
To ensure the faxes you submit are received and processed in a timely manner please follow these five guidelines.

1. Direct your fax to the correct NAS DME department based on the contact section of the NAS website, as well as the fax number listed on the letter requesting documentation to be sent to our office.
2. Submit a fax cover sheet, which includes the total number of pages, NAS DME department name, supplier name, and contact information.
3. Submit all documents in one fax transmission, as there is not a system in place to consolidate multiple responses to a single claims inquiry, appeals, etc.
4. Submit a separate fax for each claim, inquiry or response with all of the supporting documentation attached for that specific claim.
5. Review the clarity of the document being faxed to ensure the content will not be distorted if faxed due to highlighting or shading from previously faxed pages where readability may further diminish if re-faxed.

Interactive Voice Response (IVR) System Updates (877-320-0390)
The NAS IVR system was improved June 15, 2012. The same or similar DME inquiry feature now distinguishes between the statuses of Certificates of Medical Necessity (CMN) or DME Information Forms (DIFs). It also restricts modifier entries to only the applicable options, researches patient history in excess of five years, and notifies the supplier when HCPCS that are not eligible for same or similar inquiries cannot be found on the IVR system. Additional details of each enhancement are provided on our website in an article on the What's New section of our website. The use of the IVR is mandatory for all same or similar inquiries. Customer service representatives will be able to help redirect and train callers to successfully use the IVR for all same or similar inquiries.

Effective May 4, 2012, the IVR system was enhanced to offer an overlapping claims inquiry option for claimants denied as duplicate or due to frequency or overutilization. The IVR offers information on other claims that potentially led to the denial. The specific ANSI messages reported on the remittance advice for claims for which suppliers are able to utilize the new feature are listed as follows:

- N115 and N150 reported for the same line, this is for frequency and overutilization, and
- N111 and N18 reported for the same line for a duplicate.

Effective July 9, 2012, suppliers will be redirected to the IVR for basic questions. NAS classifies basic inquiries to include eligibility, claims status, same or similar equipment, duplicate remittance advice order request, and the number of oxygen rental months. This also requires suppliers to authenticate themselves by providing their National Provider Identifier (NPI), their Provider Transaction Authorization Number (PTAN), and the last five digits of their Tax Identification Number. NAS customer service representatives will provide training on the proper use of the IVR, as well as provide guidance on where IVR educational resources may be obtained.

DME Medical Director Addition
NAS is pleased to announce that we have added an additional DME Medical Director. Dr. Barbara O'Neal comes to NAS from River Trust, and had previously worked on the reconsideration contract. Dr. O'Neal will share responsibilities with Dr. Dick Whitten, and her DME knowledge will be an asset to NAS as well as our supplier community. Thank you, and welcome aboard, Dr. O'Neal.

Questions Asked During ACT

1. **When billing diabetic supplies, should the number of times the patient is testing (two, three, four times a day) be entered within the narrative portion of the claim or should a supplier enter what the physician has ordered?**
   NAS does not require suppliers to enter the frequency within the narrative on the claim submission to reflect the beneficiary's testing frequency. Suppliers need to make sure the unit(s) of service and the correct amount are billed based on the order and supporting medical documentation.

2. **What is the proper code to bill for an attendant control after a power wheelchair has already been dispensed and the patient's condition no longer allows them to operate the power wheelchair (i.e., muscular dystrophy and on a ventilator)? Documentation demonstrates the patient would be able to use an attendant control instead of the previously issued beneficiary operated drive control system. However, guidelines indicate if the attendant control is added in addition to a beneficiary operated drive control system, it will be denied as non-covered. Since the condition changed after the beneficiary operated drive control system was provided, and HCPCS E2331 would deny as noncovered, what step can a supplier take?**
   Medicare will not pay for an attendant controlled system in addition to a beneficiary operated drive control system. When the attendant controlled system is billed, the item will most likely deny as not reasonable and necessary. Due to the change in the medical condition, a supplier may need to request a written redetermination in order to demonstrate the change in medical condition in order to have Medicare's initial claim processing decision overturned.

3. **A beneficiary has an oxygen concentrator that has reached the rental month cap. Now the physician has prescribed liquid oxygen. Can a supplier bill Medicare for the portable as well as the contents?**
   If a supplier is adding a portable system to the stationary system, the policy requires that the supplier obtain a revised CMN submit it to Medicare with the portable system. This will begin a new 36 month period for the portable, liquid system. And because the concentrator is capped, the supplier can also bill for contents for the liquid portable system.

4. **If a hospitalist orders oxygen for a patient and then the beneficiary is discharged to their family doctor, who is required to complete and sign the CMN?**
   Suppliers want to make sure the physician who ordered the oxygen signed the CMN. NAS understands it may be difficult to get the hospitalist to complete that CMN. In those cases, a supplier may want to go to the beneficiary's primary care physician to have them review the beneficiary's hospital chart notes and see if they will actually sign that CMN as a treating physician. The primary care physician must be willing to sign off and order the oxygen.

5. **A specialized enteral formula, B4154, has been billed and denied by Medicare. A redetermination was submitted and the denial was upheld by Medicare; the supplier did not pursue a reconsideration request. The supplier internally reviewed the claim and confirmed their beneficiary did not qualify for the formula. Instead, it was determined the formula should have been billed as a supplier-authorized free upgrade without charging the beneficiary or issuing an Advanced Beneficiary Notice of Noncoverage (ABN). Knowing if the B4154 specialized enteral formula was billed again, it would deny with ANSI Reason Code CO-18 (duplicate claim/service). Can the supplier bill the free upgrade to the B4150 formula for which the patient qualifies considering an appeal had been submitted previously?**
   If a claim had not been received, and the supplier had not been overpaid, an upgrade claim could have been submitted following the upgrade rules. The B4154 could have been billed with the GZ modifier and then the B4150 would have been billed with the GK modifier to reflect a supplier-authorized free upgrade. Because this has begun the appeals process, the supplier would need to pursue the next level of the appeals process, the reconsideration, and support the medical necessity for the B4150 with the DIF and related medical records. The supplier should also clearly request a modification to the claim to reflect the authorized free upgrade.

6. **If a finger pulse oximeter test is done in the office by the physician's nurse, is that acceptable? A denial was received through redeterminations when a nurse, who identified themselves as a specific physician's nurse, wrote the information within the medical record.**
   Yes, if the test is done under the supervision of the physician this would be acceptable. NAS Medical Review confirmed it is appropriate as long as it is a qualifying study with a saturation level below 88 percent.

7. **When billing Positive Airway Pressure (PAP) devices, a supplier enters a narrative on the claim that the beneficiary needed new headgear to be compatible with the new mask. Would that be paid by Medicare? If not, what would be paid?**
   No, that would not be paid. There is a utilization allowance for the actual mask and if a supplier is exceeding that allowance then the claim will deny as not reasonable and necessary. The fitting and the type of mask that was ordered should all be taken into consideration, either during the sleep study or during their trial period. If the beneficiary does need new headgear, unfortunately, Medicare cannot allow more than one per the utilization guideline within the PAP Local Coverage Determination.

8. **If a beneficiary switches from an Advantage Plan to traditional Fee-For-Service (FFS) Medicare, or vice versa, and the beneficiary is in the middle of a DMEPOS capped rental, does their coverage start date begin new or would the prior insurance coverage and payments transfer to the new form of Medicare?**
   Medicare FFS is completely separate from Medicare Health Maintenance Organizations (HMOs0 or Advantage Plans. They are considered a completely separate primary insurance plan with no coordination of benefits between the two from a Medicare DME MAC perspective. NAS cannot speak for how other insurance companies coordinate Medicare FFS payments for their insured members. If a beneficiary receives their DMEPOS and does not have a break in service while they go from fee-for-service to Medicare Advantage and then back to FFS, only the months processed by the FFS Medicare contractors would count toward the rental period. For example:

   - A beneficiary had oxygen ordered and billed for January and February. The beneficiary continued to need and use their oxygen but had Medicare Advantage or HMO coverage March, April and May. The beneficiary returned to Medicare fee-for-service coverage in June. In this situation, NAS, as the Medicare fee-for-service DME contractor, would consider June the third rental month and a new order would not be required.
   - If a beneficiary came to Medicare fee-for-service after having Medicare Advantage or a different primary insurance company pays for the first and subsequent months of rental, the beneficiary would need to see their physician to qualify and order DMEPOS according to the Medicare LCDs. This would start an entirely new coverage period.

9. **We have a discrepancy with the fee schedule price for HCPCS E2366 (battery charger, single mode). The Hawaiian fee schedule is $98.64 for a sale and $128.49 for a used one while continental states' allowable is $244.06 for a new one. How can this be corrected for Hawaii to be a reasonable allowable?**

Fee schedules are not established by the DME MACs. Suppliers need to work with their CMS regional office to discuss discrepancies and concerns. CMS has a website that offers a map that reflects which states are in each CMS Regional Office. The CMS website also offers downloadable files including contact information for each Regional Office. The CMS Regional Office contact specific for the Hawaii concern is http://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/Downloads/SanFranciscoRegionalOffice.pdf.

10. **If after a patient has been capped, is a supplier still allowed to have a service charge or a maintenance fee?**
Suppliers are not able to bill a service charge. For oxygen, after the equipment has gone through the 36 month cap, suppliers are allowed to bill for actual maintenance and service that has been performed. It is recommended the maintenance and servicing occurs within the first month, six months after the 36 month cap per published Medicare guidelines. There are guidelines for delayed maintenance and service, which are located on our website https://www.noridianmedicare.com/dme/news/docs/2010/06_jun/mm6990.pdf.

11. **A patient comes in with a doctor's order and is taken on to service walkers, wheelchairs, cushions, etc., and at the time of setup, the patient indicates they have seen their physician for a face to face examination for the item that is being delivered. After the supplier bills Medicare, they request doctor's notes for information on the visit and learn the beneficiary actually did not have the face to face visit with the physician. The supplier did not obtain a signed ABN at the time of delivery because everything seemed in order. What can a supplier do instead of "writing off" the product or rentals? Is a supplier able to bill the beneficiary directly without an ABN because the patient told us they had a face-to-face visit with the physician?**
No, if a supplier did not execute the ABN prior to dispensing the item, the supplier would be liable for that item when the claim is reviewed by NAS staff. When a supplier receives a physician's order, it is their responsibility to make sure the coverage criteria are met prior to dispensing the equipment to the beneficiary. Suppliers need to do a thorough intake and assessment, making sure the beneficiary meets the coverage criteria. Certain policies require that the beneficiary has a face-to-face examination within 30 days prior to dispensing the item, such as oxygen. The PMD policy requires a face-to-face examination occur within 45 days of the seven-element order. If there is documentation to support that the beneficiary needs a cane or a walker and the beneficiary did not have a face-to-face evaluation within 30 days, that may not be a concern for that type of DMEPOS as long as their physician's documentation and the beneficiary's medical records support that they needed the item. Face-to-face examination requirements are policy-specific.

    Follow-up Question: Does a hospital visit count as a face-to-face visit with a physician?
    Yes, if the beneficiary saw a physician in the hospital and that physician determined that the beneficiary needed a walker, which would be acceptable medical documentation with additional support being the reason the patient is in the hospital.

12. **Doctors in hospitals are documenting the need for oxygen within the discharge notes. Suppliers have experienced situations in which these physicians are not writing a separate order for the oxygen. During the beneficiary intake process, the supplier identifies this discharge note in place of the order for the oxygen. In this situation, does the supplier need to contact the doctor and request the doctor write a prescription from that day forward, or can we use the discharge summary as our order for oxygen?**
If the supplier has the discharge summary before dispensing the item and it is clear that the oxygen has been ordered by a physician based on that information, that discharge summary could serve as the dispensing order. A supplier needs to follow-up with either a detailed written order or the CMN (including the details within Section C). If the discharge summary is by the physician and indicates the beneficiary is being discharged with oxygen, and as long as the physician is following up with completing and signing the CMN, the supplier would not have to go back and get a separate written prescription. The signed CMN is needed.

13. **A supplier is getting a lot of new customers that previously received their chairs from a different supplier who is no longer doing business, is under investigation, etc. The new supplier believes the beneficiary is in a chair but does not appear to meet the coverage criteria or did not at the time the chair was provided. The new supplier is being asked to repair, not replace the chair. Should the supplier gather the documentation from the ordering physician instead of the prior supplier which would demonstrate that coverage criteria for the chair are met?**
Medicare will only pay for repairs to medically reasonable and necessary items. If the beneficiary did not meet the coverage criteria, Medicare would normally have denied the claim for the wheelchair as not reasonable and necessary; therefore, the repairs would also be denied. An ABN would be an option for the new supplier if they choose to accept this new beneficiary as their customer to protect themselves from liability.

Follow-up question: A beneficiary may meet the coverage criteria and have a claim processed and paid by Medicare without having been selected for pre-payment claim review. The medical documentation may not be adequate if the claim is selected for a post-payment review. Should the new supplier have the beneficiary work with their physician to demonstrate they meet coverage criteria in order to repair the chair?
If a chair, upon review, does not meet the documentation requirements or the sequence of events requirements (i.e., the beneficiary did not have the face-to-face examination prior to the seven-element order, they did not have the detailed product description) then they did not qualify for the chair. This is a difficult situation; however, having the beneficiary begin the process may be a good option when there is not another Medicare claim payment involved for the delivery of the chair. A supplier may want to have the beneficiary work with 1-800-Medicare to investigate the claim to see if they can have it reviewed if it was originally paid incorrectly.

14. **A beneficiary in a skilled nursing facility had his/her last Medicare covered sleep study in 2003 and now needs a new PAP device. Does the beneficiary need to have a new sleep study in order to receive a PAP device? When PAP devices are older than five years does the beneficiary need to have a new sleep study performed?**
There are specific guidelines in the PAP LCD that suppliers need to follow when the beneficiary needs a replacement due to the reasonable useful lifetime. The beneficiary needs to have a face-to-face examination with their physician, the medical records need to indicate the beneficiary continues to use and benefit from the device and they must have a diagnosis of obstructive sleep apnea (OSA) but there is no requirement for a new sleep study or new trial period.

15. **A beneficiary using ostomy supplies had their surgery nine years ago. The medical records from the primary care physician and beneficiary's current gastroenterologist have no reference to the surgery or the continued use of ostomy supplies. Because this is a lifetime need, the challenge for the supplier during their intake process is to have current medical records supporting the prescription. What actions can Medicare recommend for this situation?**
According to the CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity (PIM) Manual, Chapter 5, a supplier must have more than a prescription to support items dispensed and billed to Medicare; medical documentation to support the coverage criteria being met is required. The scenario described does not appear to meet the criteria. The beneficiary should see their physician to discuss their medical condition so the continued need and use for the ostomy supplies will be documented in their medical record.

16. **A beneficiary had two blood gas study tests performed. The first test resulted in the beneficiary meeting the Group 1 qualification with a room air saturation of 74 percent. The physician's order used the second, more recent test in which the beneficiary was tested on 5 liters per minute while ambulatory and resulted in 87 percent. The 5 liters per minute, as ordered by the physician and included on the CMN, was billed to Medicare resulting in an initial claim denial as well as a denial at the redetermination appeals level.**
When a beneficiary is tested on 4 or more liters per minute, that beneficiary still needs to fall into the Group 1 or Group 2 criteria defined in the LCD. The policy indicates a beneficiary can qualify for oxygen as long as they fall into Group 1 or Group 2 coverage criteria while they are on that oxygen. If the beneficiary is on 5 liters per minute and they're falling into Group 1 or Group 2 criteria, it should be allowed. But if they're not falling into Group 1 or Group 2 criteria it won't be allowed. The supplier is encouraged to work with the physician regarding the LCD, coverage, and which qualifying test would need to be entered in Section B of the CMN.

17. **Suppliers understand that the Medicare guidelines for beneficiaries who are on sleep therapy cannot have their oxygen covered until the beneficiary is in a chronic, stable state. If the patient is not compliant with their CPAP therapy and the doctor does a sleep test and the beneficiary is still hypoxic, is this considered not a chronic, stable state? Physicians are indicating the beneficiary tried and failed when in fact the beneficiary was noncompliant.**
Yes, if the beneficiary is not in a chronic, stable state for their OSA because they are not compliantly using their PAP device, then they would not qualify for oxygen. The doctor would need to retest. If the beneficiary is noncompliant, they are not in a chronic stable state for their OSA and would not qualify per the Oxygen LCD or the Home Use of Oxygen National Coverage Determination (NCD) 240.2.

18. **There have been HCPCS E0570 (Nebulizer, with compressor) in combination with the rental modifier being denied as an invalid, missing or incomplete HCPCS. What would be the proper code for a monthly nebulizer rental?**
NAS does deny claims if the LCD required modifiers are not included on the claim. An educational article reminding suppliers of the Nebulizer LCD L11488 modifier criteria was published November 2011 and is available

on the NAS website, https://www.noridianmedicare.com/dme/news/docs/2011/11_nov/nebulizer_claims_may_be_denied_without_modifier_ko_kp_or_kq.html.

19. **Are upgrades allowed on CPAP supplies when a beneficiary elects to have a more extensive mask than what would be allowed by Medicare?**
No. Medicare covers the mask but does not consider it an upgrade if it is simply a more expensive type of mask. Medicare suppliers who enrolled as "non-participating" have the option of not accepting assignment on a claim-by-claim basis which would allow additional reimbursement options. A difference in price alone does not warrant an upgrade. The beneficiary needs a mask to use with their PAP device. If the quantities of masks that they wanted were above what Medicare allowed, which is one every three months, then that could potentially be an upgrade regarding the quantity of masks.

20. **When a pressure wound is created due to surgery, the Negative Pressure Wound Therapy (NPWT) Pumps LCD references "Evaluation of and provision for adequate nutritional status" within the Indications and Limitations of Coverage and/or Medical Necessity section A1. If the beneficiary gets the wound in a homebound-state, how the nutritional status is being addressed directly affects the wound itself. However, when the wound is created because of surgery, the nutritional notes offered would not be a driver for the wound's origination. Are nutritional notes needed for the surgery-oriented wounds which are addressed in Section B2 of the LCD?**
The LCD indicates, "A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion A or B is met." Therefore, if the beneficiary meets the criterion B, Ulcers and Wounds Encountered in an Inpatient Setting, adequate nutritional status (dietary notes) would not be required. Dietary notes would only be required when the beneficiary meets coverage as defined in criterion A.

21. **A patient with Chronic Obstructive Pulmonary Disease (COPD) has been in the emergency room for shortness of breath and was discharged home on oxygen. In order to have the oxygen covered by Medicare, the beneficiary needs to be in a chronic stable state. Is that patient being discharged considered in a chronic stable state, or does the beneficiary need to do a follow up with their physician within 30 days?**
If the beneficiary is in the emergency room for a respiratory issue, they most likely have not been in a chronic stable state. The documentation would need to support that by the time the beneficiary was discharged, they had progressed to a chronic stable state and were not experiencing any type of acute condition that sent them to the emergency room in the first place. It may be difficult to support, but if it is clearly indicated, oxygen could be allowed by Medicare.

22. **There have been denials for HCPCS E1028 (Wheelchair accessory, manual swingaway) indicating the item is already included as part of other services. The LCD provides an example of a retractable joystick mounting that would be covered. Is this HCPCS always initially denied and then suppliers must pursue the redetermination for possible coverage based on medical necessity?**
When the E1028 is billed, the accessory must also be billed; if there are multiple units of E1028, there need to be multiple accessories that the removable hardware is going to be associated with on the same claim. If the item is not removable hardware, a denial indicating it is part of other services would be accurate. An article titled, "Mounting Hardware - E1028 – Billing Reminder" was published by NAS and addresses this concern with specific instruction regarding narrative requirements. If the claim does deny, the redetermination process is available and suppliers should have all supporting documentation prepared and submitted with that appeal.

23. **Approximately once every three months a supplier would call the beneficiary and ask how their CPAP mask is working, do they need their unit checked, and is the pressure appropriate. Is a supplier still allowed to ask if a beneficiary needs a new cushion or how their supplies are working for them?**
There are very specific guidelines for refills of non-consumable items such as CPAP supplies that suppliers need to follow. When checking with beneficiaries, clearly document what is wrong with their current item (i.e., cushion is deflated, strap broken on the head gear) before the refill is dispensed. NAS published an article with additional details regarding refill requirements, "Items Provided on a Recurring Basis and Request for Refill Requirements – Revised – June 2012."

24. **If documented by a therapist, walkers used by beneficiaries for transfer purposes had been paid when the beneficiary already had a different mobility assistive device. Is that no longer allowed?**
That is no longer allowed. There is an algorithmic process that suppliers need to pursue to provide the most reasonable item; either the beneficiary needs a walker or they need a wheelchair which best suits that beneficiary. If the beneficiary is using a walker, they do not need the wheelchair so Medicare will deny the wheelchair. An ABN could be issued in this situation if both are requested for transfer purposes.

25. **After a doctor reviews the sleep study and makes notes and interprets the study, do they actually need to sign their own notes even though the notes are from the doctor? Would the order be acceptable to cover a CPAP? Would a hospital's internal process for signing records be sufficient? How does the authoring signature and date of medical records become the responsibility of a DME company?**
All medical records need to be signed and dated by the author of the record per authentication requirements outlined in the CMS Internet Only Manual, Program Integrity Manual in an acceptable, legible electronic or hand-written format. If signed by the author electronically, it needs to indicate that it is "signed electronically." The order itself is not medical documentation. The lab results or the chart notes and the hospital notes are medical documentation that CMS indicates must be signed and dated by the author. If these records are not signed and dated, Medicare contractors cannot use them when reviewing a claim for payment. While processing claims, there are times Medicare will send a letter asking that a physician submit an attestation that the records for the beneficiary have been authored by that physician. Suppliers may obtain an attestation as part of their process too. Suppliers should be aware there are times a referral source, such as a hospital, may fax suppliers the documentation before they have internally obtained the physician signature. It is the supplier's responsibility to have the proper documentation and that would include the signed medical records. The DME MAC Medical Directors have developed a reference letter suppliers can use to work with their referral sources regarding medical record authentication, signature requirements, and attestation statements.

26. **How should a supplier document what is wrong with CPAP or ostomy supplies using the refill process? There are items that degrade over time such as filters, cushions, age of the product, cleanliness to avoid bacteria, and headgear straps as well as items that are dispensed in three month increments**.
The supplier will need to determine their documentation system, ledger, or process that reflects the discussion held with the beneficiary, why it is reasonable and necessary to dispense more items, the date of the conversation, etc. When items are being dispensed on a recurring basis, there needs to be refill requests documenting why the item is being refilled. For non-consumable items, suppliers need to document the specific reason why they are refilling those items. The requirement is that the supplier check with the beneficiary no sooner than 14 days prior to the next delivery date and that the item is not dispensed any sooner than 10 days prior to end of utilization. The refill requirements have been existing CMS regulations and are located within the following articles:

    - https://www.noridianmedicare.com/dme/news/docs/2012/06_jun/items_provided_on_a_recurring_basis_and_request_for_refill_requirements.html
    - https://www.noridianmedicare.com/dme/news/docs/2011/07_jul/mm7452.pdf

For incontinence supplies that are billed in three month increments, the contact would occur no sooner than 14 days prior to the exhaustion of three months supplies. This would not be a month-by-month contact but instead it would occur approximately once every three months based on the product usage, break-down of material, loss, etc.

Follow-up question: Where should the rationale for the refill be documented (i.e., on the delivery ticket, as a notation in the patient's electronic record)? Is a delivery ticket a sufficient place to notate that information?
When suppliers reach out to their beneficiaries following the refill guidelines and timeframes, the tool selected by the supplier to track their customer interactions, orders, etc would not be something Medicare can define; however, the information collected will need to be able to be produced and submitted to Medicare for claim reviews. If the delivery ticket is mailed to the beneficiary and the rationale for the refill, date of contact, etc is not reproducible within the office, the refill documentation would not be sufficient for a Medicare claim review.

27. **The date of service needs to be the date an item is shipped, mailed or delivered in person to a beneficiary inside of the store. Can this date of service be the same date the beneficiary is contacted?**
Medicare would not allow for automatic delivery prior to having a conversation with the beneficiary indicating the need for the refill. In a scenario where the supplier called the beneficiary ten days prior to the anticipated exhaustion date, and learned the beneficiary only had 5 days of product and needed a refill, it would be acceptable to have the date of service the same date as the date of contact. The delivery cannot occur prior to ten days before the exhaustion date.

28. **If a claim has been processed, denied initially, but later approved for payment as being medically necessary at the redetermination, reconsideration, or at the Administrative Law Judge level of appeals, can this same claim date of service be selected for a CERT review?**
The CERT contractor has a policy that specifically excludes claims from being selected for post-payment review when an appeal-level determination has been completed prior to the CERT selection of that claim for processing. Because an automated sample is used, the CERT may select a claim for a subsequent rental month than the original

claim that was appealed. If a supplier finds that the CERT is selecting a claim that has been found favorable through the appeal process, respond to the CERT documentation request by faxing the supplied cover sheet with a copy of the favorable appeal-level decision letter. Include a narrative that the selected claim was previously found to be favorable through appeal and should be excluded from the CERT process. NAS evaluates the CERT reviews and examples of excluded appeals to discuss with the CERT contractor to continually improve the process and impact to suppliers.

29. **When replacing CPAP supplies, a supplier is adding a comment to the claim indicating why the patient needed to replace the supplies. Is the entry of this comment required?**
NAS does not require this on claim submission; however, suppliers do want to ensure they are documenting the refill requirements.

30. **When NAS completes a complex medical review, how can a supplier learn the rationale for the denial?**
When NAS conducts widespread reviews instead of targeted, supplier-specific reviews, the decision of each claim review is communicated through the supplier remittance advice. Only with a supplier-specific review would a supplier receive individualized nurse education through an NAS-initiated telephone call. To learn the details of the claim decision, suppliers can contact our call center to obtain the nurse comments regarding the decision.

31. **Can Medicare modify their process to allow a claim and the related CMN denied during a complex medical review to be removed from the claim processing system? If an item is denied, the supplier would take the equipment back and there would be a break in service. These denied claims are causing future claims by new suppliers to be denied and requiring the appeal process be pursued for each claim. Removing the CMN from the denied claim would allow the new claims and their CMNs to be reviewed upon initial submission. This situation may be for re-qualified beneficiaries.**
The process requirements cannot be changed to meet this request. When claims are denied in a complex medical review, the CMN is set to deny that claim and future claims for efficiency as well as Trust Fund protection purposes. When the appeal process is pursued for a small portion of the overall denied claims, the old, un-payable CMN is removed from the system and the payable CMN for the claim and future claims is entered into the system.

New Look for the CMS Medicare FFS Provider e-News

Starting next week, you'll notice some changes to the weekly *CMS Medicare FFS Provider e-News*. It will have the same great content, but with a new look as we transition to a new delivery system.

What's new?

- Refreshed, cleaner design with new header graphic
- Email body will be a preview of the week's e-News issue Table of Contents, with a link to the full text version of the newsletter.
- New link to subscribe or manage your subscription. Refer your colleagues.

If you do not receive the e-News on November 8, please subscribe using the link above.

Thank you for your continued interest in Medicare FFS news.

Safeguarding Your Medical Identity Web-based Training Course

In April 2012, CMS produced a medical identity theft Web-based training course that is currently available on the CMS Medicare Learning Network Website (see below). The *Safeguarding Your Medical Identity* course is designed to educate Medicare providers on how to recognize the risks of medical identify theft and the resources available to protect their medical identity.

The training course features Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity. It discusses the scope and definition of medical identity theft, common schemes using stolen identities, consequences for victims, mitigation strategies, and appropriate actions for potential victims of medical identity theft.

Health care professionals can earn a total of 1.0 hour of Continuing Medical Education (CME) credit, after completing a post-assessment with three questions. Registration is required to earn CME credit, and instructions for registration can be found at:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf.

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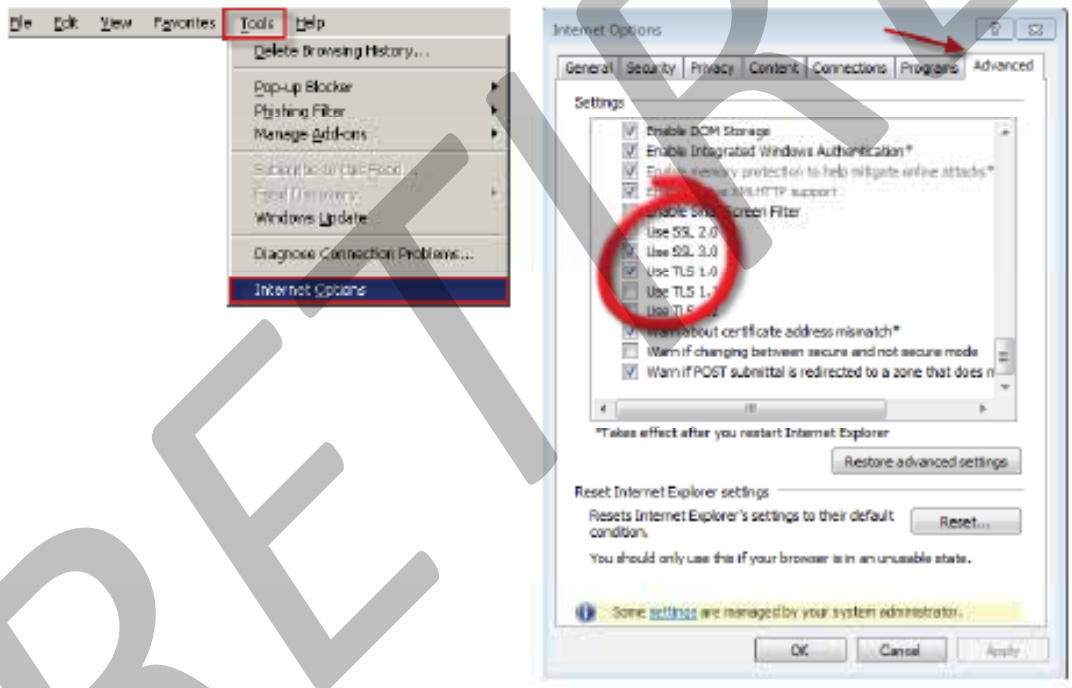
Medicare Part A, Part B, and Durable Medical Equipment

Endeavor Configuration Setting Change – Effective August 13, 2012

Due to CMS security requirements, users may encounter difficulty with the Endeavor program beginning August 13. To support TLS Version 1.0 sessions and ensure proper end user access, follow the steps below and make certain your web browser configuration is appropriately set.

Microsoft Internet Explorer Users

- In the toolbar, go to "Settings" or "Tools" and select "Internet Options."
- Select the "Advanced" tab.
- Ensure BOTH "Use SSL 3.0" and "Use TLS 1.0" contain a check mark.



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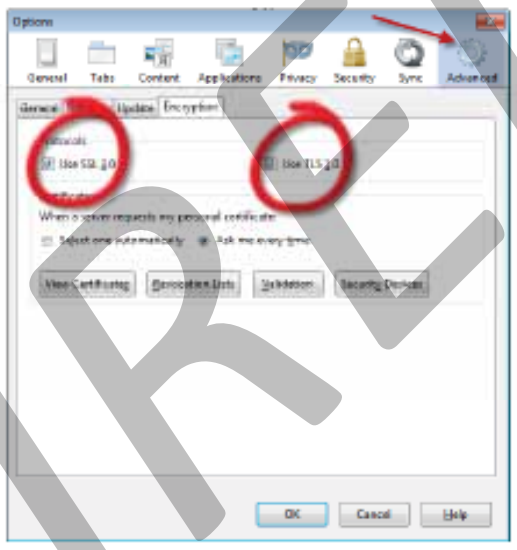
Mozilla Firefox Users

- In the toolbar, go to "Tools" and select "Options."
- Select "Advanced" and the "Encryption" tab.
- Ensure BOTH "Use SSL 3.0" and "Use TLS 1.0" contain a check mark.



After the update has been checked or completed, users may continue with their Endeavor workloads.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

IVR Requires Beneficiary Residence State Entry

The NAS Durable Medical Equipment (DME) Interactive Voice Response (IVR), 1-877-320-0390, now has a state prompting entry requirement. Suppliers who call the IVR are asked, "What state are you calling for?" Please answer by speaking or keying the state your beneficiary resides in. The touch tone options are as follows:

1. North Dakota
2. Arizona
3. California
4. Washington
5. Alaska
6. Oregon
7. South Dakota
8. Wyoming
9. Utah
10. Nevada
11. Montana
12. Nebraska
13. Missouri
14. Kansas
15. Iowa
16. Idaho
17. Hawaii
18. Guam
19. American Samoa
20. Northern Mariana (islands)
21. Other (Other States)

The state prompting feature enables NAS to run data analysis on calls coming in, do targeted education based on data analysis, and run state-specific messaging as needed.

Power Mobility Device Prior Authorization Request Status Available on NAS IVR

Effective November 9, 2012, suppliers are able to access the Interactive Voice Response (IVR) System, 1-877-320-0390, to check the status of any PMD Prior Authorization Request they have submitted. Below are the instructions for utilizing this new menu option.

To obtain the status of the PMD Prior Authorization Request, the following steps are necessary:

1. Call the IVR, 1-877-320-0390
2. Provide the state in which the beneficiary resides
3. From the main menu select Option 3 on the touch tone keypad or speak, "PMD"

When requested provide the following information:

1. National Provider Identifier (NPI)
2. Provider Transaction Access Number (PTAN)
3. Last five digits of the Tax Identification Number (TIN)

4. Beneficiary's Medicare Health Insurance Claim Number
5. Beneficiary's first and last name as it appears on the Medicare card
6. Beneficiary's date of birth
7. 5 digit alpha numeric HCPCS code submitted on the PMD Prior Authorization Request

Information Available
The IVR will provide the applicable response as follows:

- Notification that there is not a PMD Prior Authorization Request on file for that supplier, beneficiary, and HCPCS combination
- Notification that the PMD Prior Authorization Request has been received and is processing
- Notification that the PMD Prior Authorization Request has been received, completed processing, received an affirmative decision, and provide the Unique Tracking Number (UTN) necessary for claim submission
- Notification that the PMD Prior Authorization Request has been received, completed processing, received a non-affirmative decision, and provide the Unique Tracking Number (UTN) necessary for claim submission

Note: If multiple PMD requests are on file for the supplier, beneficiary, and HCPCs combination each record will be returned followed by the caveat "this may be a duplicate request". To move through the list of records say "next request" or "previous request". You can also say "repeat that" to hear the request again.

Navigation
Once all information has been provided, key or speak the selection below to continue:

Touch-tone Option	Vocal Option
1	Repeat That
4	Change the HCPCS
5	Change Medicare Number
6	Change NPI
7	Change PTAN

In the event a supplier or provider has questions regarding the PMD Prior Authorization project and are not inquiring on the status of a specific PMD Prior Authorization Request, state "PMD Questions" to be transferred to a Customer Service Representative.

Suppliers will continue to receive the detailed decision letter including the UTN in the mail. This IVR feature is intended to assist suppliers in their Medicare billing. Suppliers may access information regarding the PMD Prior Authorization demonstration on the NAS website, https://www.noridianmedicare.com/dme/prior_authorization_demonstration_pmd/.

ESRD

Implementation of Changes to ESRD Prospective Payment System Consolidated Billing Requirements for Daptomycin and Clarification of Outlier Services for Calendar Year 2013

MLN Matters® Number: MM7869
Related Change Request (CR) #: CR 7869
Related CR Release Date: November 5, 2012
Related CR Transmittal #: R2588CP
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Provider Types Affected
This MLN Matters® Article for Change Request (CR) 7869 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for End-

Stage Renal Disease (ESRD) services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7869 which provides an update to the ESRD PPS for Calendar Year (CY) 2013, including the billing requirements for Daptomycin, and the CR clarifies Outlier Services for Calendar Year 2013.

Background
The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf on the Internet) amends the Social Security Act (section 1881(b)(12); see http://www.ssa.gov/OP_Home/ssact/title18/1881.htm on the Internet) by requiring the implementation of an End Stage Renal Disease (ESRD) bundled Prospective Payment System (PPS) effective January 1, 2011.

The ESRD PPS was implemented by CR7064 (Transmittal 2134, End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services). See the MLN Matters® article, MM7064, corresponding to CR7064 at https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

ESRD Claims Reporting ESRD-Related Drugs and Biologicals
The "Medicare Benefit Policy Manual" (Chapter 11, Section 30.4.1; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf on the CMS website) lists the drugs and fluids that were included under the composite payment system, which are heparin, antiarrythmics, protamine, local anesthetics, apresoline, dopamine, insulin, lidocaine, mannitol, saline, pressors, heparin antidotes, benadryl, hydralazine, lanoxin, solu-cortef, glucose, antihypertensives, antihistamines, dextrose, inderal, levophed, and verapamil.

The manual also explicitly states, "… drugs used in the dialysis procedure are covered under the facility's composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items, or are used to accomplish the same effect, are also covered under the composite rate." Data analysis of 2011 ESRD claims indicate that ESRD facilities are reporting composite rate drugs resulting in duplicate payment to those ESRD facilities that are receiving a blended payment under the transition period and inappropriate inclusion in the outlier calculation (discussed below).

In addition, in the Calendar Year (CY) 2012 ESRD PPS final rule (see http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf on the Internet) and in CR7617 (Transmittal 150,Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012), CMS discussed alteplase and other thrombolytic drugs. CMS indicated that a clinical review of the 2007 claims used to develop the ESRD PPS revealed that ESRD facilities routinely used alteplase and other thrombolytic drugs for access management purposes. CMS also indicated that because these drugs are used to accomplish the same effect (that is, vascular access management) as a composite rate drug, they are also considered to be composite rate drugs and, therefore, should not be reported on the ESRD claim. In CR7617, CMS removed alteplase and other thrombolytic drugs from the outlier calculation but CMS did not implement edits to prevent separate payment to the ESRD facilities that are receiving a blended payment during the transition. See the MLN Matters® article, MM7617, corresponding to CR7617, at http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf on the CMS website. For CY 2013, separate payment for alteplase and other thrombolytics will not be paid separately under the composite rate portion of the blended payment for ESRD facilities receiving a blended payment during the transition.

ESRD-Related Drugs and Biologicals that Qualify as Outlier Services
Medicare regulations at 42 CFR §413.237(a)(1)(i) (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl on the Internet) provide that ESRD outlier services are those ESRD-related services that were or would have been considered separately billable under Medicare Part B for renal dialysis services furnished prior to January 1, 2011. Therefore, items and services that would have been included under the composite rate do not qualify as an outlier services.

ESRD Claims Reporting Daptomycin
CR7064 provided ESRD consolidated billing requirements for certain Part B services included in the ESRD PPS bundled payment.) See the MLN Matters® article, MM7064, corresponding to CR7064 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf on the CMS website.) All drugs reported on the ESRD facility claim that do not have an AY modifier are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore separate payment is not made to ESRD facilities. Daptomycin is included on the consolidated billing list.

Revision to ESRD Claims Reporting Daptomycin, Effective January 1, 2013
ESRD facilities have the ability to receive separate payment for Healthcare Common Procedure Coding System (HCPCS) code J0878 Injection, Daptomycin, 1 mg furnished on or after January 1, 2013, by placing the AY modifier on the 72X claim when Daptomycin is furnished to an ESRD patient that is not for the treatment of ESRD. The ESRD facility is required to indicate (in accordance with diagnosis coding guidelines) the diagnosis code for which Daptomycin is indicated.

Revision to ESRD Claims Reporting ESRD-Related Drugs and Biologicals, Effective January 1, 2013
Composite rate items and services should not be reported on the ESRD facility claim. Because ESRD facilities are continuing to inappropriately report composite rate drugs, CMS developed a list of certain drugs and biologicals based on the 2011 claims data that are considered to be composite rate drugs (see attachment A of CR7869, which is at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2588CP.pdf on the CMS website). ESRD facilities that are receiving reimbursement under the transition and have been inappropriately reporting drugs and biologicals considered to be in the composite rate will no longer be separately paid in the composite rate portion of the blended payment for these drugs effective January 1, 2013. In addition, because these ESRD-related drugs are considered to be in the composite rate they are also considered to be always ESRD-related. Therefore, CMS is updating the list of items and services that, effective January 1, 2013, are subject to consolidated billing requirements which can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/ESRDpayment/Consolidated_Billing.html on the CMS website. ESRD-related drugs and biologicals located on this list are not eligible to be paid separately with the AY modifier.

The list of ESRD-related drugs in attachment A of CR7869 is not an all-inclusive list, and ESRD facilities should not be reporting any composite rate items and services on the ESRD claim. ESRD facilities should not change treatment behaviors to receive separate payment. For example drugs and biologicals used for the purpose of access management should not be reported on the claim because, in accordance with the "Medicare Benefit Policy Manual" (Chapter 11, Section 30.4.1; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf on the CMS website) those drugs are considered to be composite rate drugs. CMS is continuing to monitor the claims data for drug utilization.

The list of ESRD-related drugs and biologicals on attachment B of CR7869 is not an all-inclusive list of the drugs and biologicals that are included in the ESRD PPS. For example, any anti-infective drugs that are used for access management are included in the ESRD PPS. Attachment B has been updated to reflect 2011 claims data. However, any drug or biological (even if not one of the categories in attachment B) that is used for the treatment of ESRD (that is, ESRD-related) is included in the ESRD PPS and is not separately paid.

Clarification of ESRD-Related Drugs and Biologicals that Qualify as Outlier Services, Effective January 1, 2013
Because ESRD facilities are continuing to inappropriately report composite rate drugs, composite rate drugs are incorrectly being included in the outlier calculation. Therefore, we developed a list of drugs and biologicals (attachment A) from the 2011 claims data that are considered to be composite rate drugs. This is not an all-inclusive list and ESRD facilities should not be reporting composite rate items and services on the ESRD claim. The ESRD-related drugs and biologicals listed on attachment A will not qualify as outlier services.

Peginesatide, Effective January 1, 2013
Peginesatide is a new Erythropoiesis-Stimulating Agent (ESA) drug approved for the treatment of anemia in dialysis patients. Peginesatide has been assigned a permanent HCPCS code of J0890. This permanent code replaces the temporary code issued Q2047. Peginesatide is subject to ESRD consolidated billing requirements. The drug description indicates use while on dialysis, therefore, it would be inappropriate to bill J0890 with modifier AY. The consolidated billing requirement may not be overridden with the use of the AY modifier.

Additional Information
The official instruction, CR7869, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2588CP.pdf on the CMS website.

MLN Matters® article, MM7064 "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services" found here http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf on the CMS website.

MLN Matters® article, MM7617 "Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012" found here http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf on the CMS website.

Quarterly Update to ESRD Prospective Payment System

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

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

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

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

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

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

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

Consolidated Billing Changes
ESRD-Related Drugs and Biologicals
The following new code is being added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management treatment effective July 1, 2012.

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

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

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

receiving a blended payment during the transition will receive separate payment under the composite rate portion of the blend effective July 1, 2012.

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

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

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

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

Changes to Items and Services that Qualify as an Outlier Service
CMS is removing the following Current Procedural Terminology (CPT) code 83875 (Assay of Magnesium) from the list of outlier services. The "Assay of Magnesium" laboratory test was a composite rate service under the basic case-mix adjusted composite rate system. Consequently, it is considered a renal dialysis service under the ESRD PPS. Therefore, this laboratory test does not qualify as an outlier service under 42 CFR 413.237 **effective October 1, 2012.**

CR7858 also includes the following two attachments:

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

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

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

FRAUD AND ABUSE

CMS Fraud Prevention Training Modules for Providers

In June 2012, CMS produced two fraud prevention training modules that are currently available on the Medscape website. These modules provide key information to health care practitioners and professionals on how they can assist CMS in preventing fraud and abuse, as well as highlight CMS' efforts to fight fraud and abuse and explain how health care professionals can be part of these efforts.

The first module, "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients," presents CMS' provider-focused fraud awareness and prevention initiatives. The goal of this activity is to provide health care professionals with actionable ideas for working with CMS and other agencies that investigate suspected fraud and abuse. This module also informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module can be found here: http://www.medscape.org/viewarticle/764496

The goal of the second module, "How CMS Is Fighting Fraud: Major Program Integrity Initiatives," describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this activity is to increase awareness amongst providers about the strategies CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module can be found here: http://www.medscape.org/viewarticle/764791

The modules feature Dr. Peter Budetti, Deputy Administrator of the Center for Program Integrity; Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity; and Mary Agnes Laureno, former Deputy Director of the Center for Program Integrity.

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of http://www.medscape.com.

Instructions for Accessing the Medscape Modules

1. Access the website: http://www.medscape.org Medscape accounts are free of charge.
2. Registration is on the upper right hand corner of the home page of http://www.medscape.org next to the log in field.
3. To access the modules, first enter your membership log in information.
4. To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: http://www.medscape.org/viewarticle/764496.
5. To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: http://www.medscape.org/viewarticle/764791.

HOSPITAL BEDS

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

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

The results of the review, for the item E0260, identified 511 claims of which 453 were denied. A total of 14 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 88%. Total dollars allowed were $7,392.20; total dollars denied were $56,490.05.

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

The following are the top reasons for denial:

1. Criteria for fixed height hospital bed of LCD L11572 not met.
2. Criteria for the semi-electric hospital bed of LCD L11572 not met.
3. No office notes/medical records provided.
4. Documentation submitted does not support medical necessity for item requested.

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

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

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

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

B. For any of the above hospital beds , if documentation does not justify the medical need of the type of bed billed, payment will be denied as not reasonable and necessary.

C. Per LCD L11572, 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.

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

ICD-10

Partial Code Freeze Prior to ICD-10 Implementation

MLN Matters® Number: SE1240

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

What You Need to Know
At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F issued on August 24, 2012. This final rule is available at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests

that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2015 once the partial freeze has ended.

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

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

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

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

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

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

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

Updated ICD-10 Implementation Information

MLN Matters® Number: SE1239

Provider Types Affected
This MLN Matters® Article is intended for all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What You Need to Know
This MLN Matters® special edition article replaces article SE1019 and provides updated information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States

health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on the Centers for Medicare & Medicaid Services (CMS) website.

Thus, on **October 1, 2014**, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry.

Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 Implementation Compliance Date

On October 1, 2014, CMS will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
  - There will be **no** delays.
  - There will be **no** grace period for implementation.

Important, please be aware:

- **ICD-9-CM codes will not be accepted for services provided on or after October 1, 2014.**
- **ICD-10 codes will not be accepted for services prior to October 1, 2014.**
  You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2014, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2014.

  Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2014.

Note: Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes.

What are the Differences Between the ICD-10-CM/ICD-10-PCS and ICD-9-CM Code Sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

What are Benefits of the ICD-10 Coding System?

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement

- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM Code Use and Structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is 3 to 7 characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters 3-7 are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1. Laterality (left, right, bilateral)
   For example:
   - C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
   - H16.013 – Central corneal ulcer, bilateral
   - L89.022 – Pressure ulcer of left elbow, stage II
2. Combination codes for certain conditions and common associated symptoms and manifestations
   For example:
   - K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
   - E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
   - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
3. Combination codes for poisonings and their associated external cause
   For example:
   - T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela
4. Obstetric codes identify trimester instead of episode of care
   For example:
   - O26.02 – Excessive weight gain in pregnancy, second trimester
5. Character "x" is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character
   For example:
   - T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
   - T15.02xD – Foreign body in cornea, left eye, subsequent encounter
6. Two types of Excludes notes
   Excludes 1– Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).
   For example:

- Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

7. Excludes 2 – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).
   - L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)
8. Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level) For example:
   - T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
   - Z67.40 – Type O blood, Rh positive
   - Y90.6 – Blood alcohol level of 120–199 mg/100 ml
9. A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)
   For example:
   - E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
   - F10.182 – Alcohol abuse with alcohol-induced sleep disorder
   - T82.02xA – Displacement of heart valve prosthesis, initial encounter
10. Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders
    For example:
    - D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
    - D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now 4 weeks rather than 8 weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review "Basic Introduction to ICD-10-CM" audio or written transcripts from the March 23, 2010 provider outreach conference call, which is available at http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

ICD-10-PCS Code Use and Structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric. The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals. For example:

- 0FB03ZX - Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ - Repair, upper esophagus, open approach

Help with Converting Codes

The General Equivalence Mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward

mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products;
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use can be found on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/index.html (select from the left side of the web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings" (http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website).

What to do Now in Preparation for ICD-10 Implementation?

If you have not already done so, here are the steps you need to consider to implement ICD-10:

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types.
- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims.
- Learn about system impact and 5010.
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation.
- Review and refresh knowledge of medical terminology as needed based on the assessment results.
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology).
- Plan to provide intensive coder training approximately 6 -9 months prior to implementation.
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much.

Additional Information

To find additional information about ICD-10, visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page** -This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/Medicare/Coding/ICD10/index.html and check back regularly for access to ICD-10 implementation information of importance to you. Note: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

ICD-10 CONT'D

- **CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.
- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/Medicare/Coding/ICD10/index.html, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.
- **See MLN Matters® Special Edition Article, SE124**0, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1240.pdf for a discussion of a partial freeze on ICD-10 code set prior to implementation.

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

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

LCD AND POLICY ARTICLE REVISIONS

Summary for August 30, 2012

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

Glucose Monitors
LCD
Revision Effective Date: 11/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Format and layout of basic coverage and high utilization criteria
Revised: Order requirements language to specify a "detailed written order"
Revised: Word "Patient" to "Beneficiary"
Clarified: Coverage of laser lancing devices and lens shield cartridges
DOCUMENTATION REQUIREMENTS:
(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Documentation of beneficiary training

Tracheostomy Care Supplies
LCD
Revision Effective Date: 08/01/2012 (August Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: UOS for A4456 from 1 to 50 (clerical correction from 1 box to the 50 units per box)

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

Summary for September 2012

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

Oxygen and Oxygen Equipment
LCD
Revision Effective Date: 10/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Cluster Headache section to include NCD 240.2.2 coverage requirements (Effective 10/01/2012)
Added: Change in payment category to existing cluster headache oxygen rules
Revised: Clarified home sleep testing requirements are limited to stand-alone overnight pulse oximetry
Revised: Clarified that exercise testing is limited to directly supervised testing
Revised: Expanded qualification testing for high liter flow to greater than or equal to 4 LPM
HCPCS CODES AND MODIFIERS:
Revised: Modifier QF and QG narratives
DOCUMENTATION REQUIREMENTS:(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Revised: Refill requirements to clarify documentation of the "near exhaustion" requirement
Added: Proof of delivery requirements
Revised: Information requirements for documenting R&N indications

Policy Article
Revision Effective Date: 10/01/2012
CODING GUIDELINES:
Revised: Cluster headache oxygen coding guideline

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

Summary for October 2012

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

Transcutaneous Electrical Nerve Stimulators (TENS)
LCD
Revision Effective Date: 06/08/2012
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Reformatted coverage criteria to separate the different coverage conditions
Revised: "Chronic pain" to separate CLBP from other types of chronic pain
Added: Coverage for CLBP to add diagnosis and approved study requirements (CR 7836)
HCPCS CODES AND MODIFIERS:
Added: Q0 (zero) modifier
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY
Added: Diagnosis for CLBP coverage
DOCUMENTATION REQUIREMENTS:
Revised: CMN requirements to exclude CLBP
Added: Guidance for documenting coverage
(Note: The effective date above is not applicable to the documentation revisions described below. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements
APPENDICES:
Added: Reference for PIM citations
Added: Information about "Coverage with Evidence Development" and "Clinicaltrials.gov" study identification number

Wheelchair Options/Accessories
Policy Article
Revision Effective Dated: 11/01/2012
CODING GUIDELINES:
Added: E1020/E1028 clarification and addition to bundling table

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

Summary for November 1, 2012

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

Manual Wheelchair Bases
LCD
Revision Effective Date: 03/01/2013
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Coverage criteria for K0005 to conform with DMEPOS Quality Standards reclassification as a rehabilitation product

Policy Article
Revision Effective Date: 05/01/2012 (November 2012 publication)
CODING GUIDELINES:
Deleted: Wheel size requirement of E1161

Suction Pumps
LCD
Revision Effective Date: 04/15/2012 (November 2012 publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Coverage for A4605 to link it as a supply to E0600
Revised: Moved required diagnosis codes for A4605 and A4624 from DOCUMENTATION REQUIREMENTS section to coverage section
Added: Additional ICD-9 diagnosis codes describing tracheostomy status (519.00, 519.01, 519.02, 519.09)
Revised: Wound suction pump explanation about rationale for noncoverage to improve readability
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: 519.00, 519.01, 519.02, 519.08 – ICD-9 Codes for A4605 and A4624
DOCUMENTATION REQUIREMENTS:
Revised: ICD-9 requirements for A4605 and A4624 (moved to INDICATIONS AND LIMITATIONS OF MEDICAL NECESSITY section)
Revised: Updated REFILL REQUIREMENTS to include expanded description of consumable and durable supplies as separate bullets

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

Summary for November 9, 2012

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

Oxygen and Oxygen Equipment
LCD
Revision Effective Date: 01/01/2013 (Cluster headache related items are effective 10/01/2012)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Long Term Oxygen Therapy Trial by creating stand-alone section and adding reference to APPENDICES section
Revised: Cluster Headache section to include change to codes E0424 and E0441 and clinical study ID number information (Effective 10/01/2012)
Added: Definitions for qualifying testing types to minimize confusion with other respiratory testing done for other purposes

Revised: Renamed home sleep testing to be referred to as "overnight oximetry" to minimize confusion with home sleep testing done to diagnose obstructive sleep apnea
Added: Clarification about supervision for testing
Added: Information about when the use of polysomnogram oximetry results is acceptable to justify the reimbursement of oxygen
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: V70.7 as concurrent diagnosis requirement (Effective 10/01/2012)
DOCUMENTATION REQUIREMENTS:
Added: Long Term Oxygen Therapy Trial section
Added: "Clinicaltrials.gov" ID number requirement for long term oxygen therapy trials
Added: Q0 (zero) modifier requirement to long term oxygen therapy trials
Added: V70.7 instructions for cluster headache (Effective 10/01/2012)
Added: "Clinicaltrials.gov" ID number requirement for cluster headache (effective 10/01/2012)
APPENDICES:
Added: Clinical trials information

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea
LCD
Revision Effective Date: 01/01/2013
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement language to specify a "detailed written order"
Added: Concurrent use of oxygen and PAP coverage requirements
DOCUMENTATION REQUIREMENTS:
Added: Concurrent Use of Oxygen with PAP Therapy
(Note: The effective date above is not applicable to the documentation revisions described below. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)
Revised: Prescription requirements
Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Suction Pumps
Policy Article
Revision Effective Date: 04/15/2012
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Bundling requirement for A4605 as included in payment for ventilator and supplies (applies to all ventilator codes in the Frequent and Substantial Servicing pricing category)

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

MOBILITY DEVICES

Calling NAS with Questions Regarding the Prior Authorization Demonstration for Power Mobility Devices

Beginning September 1, 2012, suppliers of California beneficiaries calling NAS DME Jurisdiction D, (877) 320-0390, with questions concerning the Power Mobility Device (PMD) Prior Authorization Demonstration will be able to contact a Customer Service Representative by following these steps. First, authenticate the NPI, PTAN and Tax Identification Number using the IVR. Next, state "PMD question". Once the call is routed to a Customer Service Representative (CSR), notify that CSR that your call is concerning the PMD Demonstration.

Additional information regarding this PMD Prior Authorization Demonstration is accessible at https://www.noridianmedicare.com/dme/prior_authorization_demonstration_pmd/.

Changing a 7-Element-Order for a Power Mobility Device

The DME MACs continue to receive questions about making a change to a 7-Element-Order for a Power Mobility Device. To minimize possible misunderstanding, it is recommended that when the need for a correction is identified, the supplier should request that the physician who completed the original 7-Element-Order complete and submit a new 7-Element-Order.

If a new 7-Element-Order cannot be obtained, a *corrected* 7-Element-Order is acceptable only when properly corrected/amended by the physician who originally signed it. A properly corrected/amended record must:

- Clearly and permanently identify any alteration or addition
- Clearly indicate the date and author of any alteration or addition
- Preserve the legibility of the original order by means of a single, narrow line made through any deletion.

Any deletion made and/or any addition written must be completed only by the physician who created the original 7-element-Order, who must legibly sign and date each change as noted above.

In addition, a corrected 7-Element-Order is acceptable only when the corrections/amendments are made prior to the completion of any Detailed Product Description (DPD). Furthermore, the correction/amendment must be completed prior to the Date of Service (DOS) of the claim.

Clarification of the Quality Standards and Accreditation Requirements for Ultra Lightweight Manual Wheelchairs

MLN Matters® Number: SE1233

Provider Types Affected
This MLN Matters® Special Edition Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs)) for certain wheelchairs and related services provided to Medicare beneficiaries.

Provider Action Needed
Effective for claims with dates of service on or after March 1, 2013, suppliers who furnish K0005 wheelchairs to Medicare beneficiaries and who are not in compliance with DMEPOS Quality Standards and Accreditation Requirements must come into compliance with these requirements or they will be required to stop furnishing these items to Medicare beneficiaries until these requirements are met.

Ultra lightweight manual wheelchairs (Healthcare Common Procedure Coding System (HCPCS) code K0005) are highly configurable manual wheelchairs for highly active full time users.

The ultra-light weight manual wheelchairs require individualized fitting and optimal adjustments for multiple features that include axle configuration, wheel camber, and seat and back angles, in addition to ongoing critical support.

These services are furnished by a Rehabilitative Technology Supplier (RTS). Therefore, these items are considered complex rehabilitative wheelchairs subject to the requirements of DMEPOS Quality Standards, Appendix B, Manual Wheelchairs, Power Mobility Devices (PMDs), and Complex Rehabilitative Wheelchairs and Assistive Technology, **Section III, Complex Rehabilitative Wheelchairs and Assistive Technology**. You must employ at least one Assistive Technology Professional effective for services on or after March 1, 2013 in order to bill Medicare for the K0005 wheelchair. See Background section of this article for further information about Appendix B.

All other lightweight manual wheelchairs are considered standard lightweight wheelchairs and are subject to the requirements of DMEPOS Quality Standards, Appendix B, Section I, Manual Wheelchairs.

Background
The complete set of requirements, including Appendix B, may be found in the booklet entitled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards," available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf on the CMS website. Here is the text of appendix B of the DMEPOS Quality Standards.

Appendix B: Manual Wheelchairs, Power Mobility Devices, and Complex Rehabilitative Wheelchairs and Assistive Technology
This appendix applies to Manual Wheelchairs, Power Mobility Devices (PMDs), and Complex Rehabilitative Wheelchairs and Assistive Technology. Manual wheelchairs include standard recliners, heavy-duty wheelchairs,

standard lightweight wheelchairs, and hemi wheelchairs, armrests, leg rests/footplates, anti-tipping devices, and other Medicare approved accessories. PMDs include power wheelchairs and Power Operated Vehicles (POVs) and accessories. Complex Rehabilitative wheelchairs are Group 2 power wheelchairs with power options, Group 3 power wheelchairs and manual wheelchairs that can accommodate rehabilitative accessories and features (e.g., tilt in place).

1. Manual Wheelchair

A. Intake & Assessment

In addition to Section II: Supplier Product-Specific Service Requirements (in the booklet entitled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards"), the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up

Refer to Section II: Supplier Product-Specific Service Requirements.

Training/Instruction to Beneficiary and/or Caregiver(s)

Refer to Section II: Supplier Product-Specific Service Requirements.

C. Follow-up

Refer to Section II: Supplier Product-Specific Service Requirements.

2. Power Mobility Devices

A. Intake & Assessment

In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up

Refer to Section II: Supplier Product-Specific Service Requirements.

C. Training/Instruction to Beneficiary and/or Caregiver(s)

Refer to Section II: Supplier Product-Specific Service Requirements.

D. Follow-up

Refer to Section II: Supplier Product-Specific Service Requirements.

3. Complex Rehabilitative Wheelchairs and Assistive Technology

In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall:

Employ (W-2 employee) at least one qualified individual as a Rehabilitative Technology Supplier (RTS) per location. A qualified RTS is an individual that has one of the following credentials:

- Certified Rehabilitative Technology Supplier (CRTS);
- Assistive Technology Supplier (ATS) (discontinued 12/31/2008);
- Assistive Technology Practitioner (ATP) (discontinued 12/31/2008);
- Assistive Technology Professional (ATP) (effective 1/1/2009).

2. The RTS shall have at least one or more trained technicians available to service each location appropriately depending on the size and scope of its business. A trained technician is identified by the following:

- Factory trained by manufacturers of the products supplied by the company;
- Experienced in the field of Rehabilitative Technology, (e.g., on the job training, familiarity with rehabilitative clients, products and services);
- Completed at least 10 hours annually of continuing education specific to Rehabilitative Technology; and
- Able to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.

3. The RTS shall:
   - Coordinate services with the prescribing physician to conduct face-to-face evaluations of the beneficiary in an appropriate setting and include input from other members of the health care team (i.e., PT, OT, etc.);
   - Provide the beneficiary with appropriate equipment for trial and simulation, when necessary;
   - Maintain in the beneficiary's record all of the information obtained during the assessment; and

Implement procedures for assembly and set-up of equipment as well as a process to verify that the final product meets the specifications of the original product recommendation approved by the prescribing physician.

4. If beneficiaries are evaluated in the supplier's facility, the supplier shall:
   - Provide the beneficiary private, clean, and safe rooms appropriate for fittings and evaluations; and
   - Maintain a repair shop located in the facility or in close proximity or easily accessible from another location of the supplier, as well as an area appropriate for assembly and modification of products.

A. Intake & Assessment

In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up

Refer to Section II: Supplier Product-Specific Service Requirements.

C. Training/Instruction to Beneficiary and/or Caregiver(s)

Refer to Section II: Supplier Product-Specific Service Requirements.

D. Follow-up

Refer to Section II: Supplier Product-Specific Service

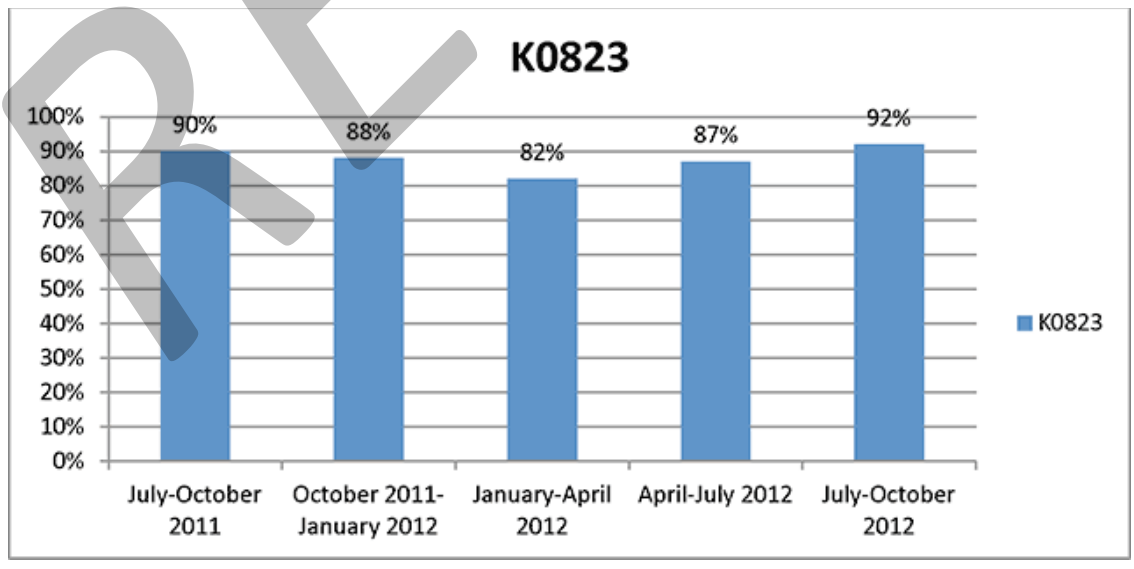
Fifth Quarter Results of Widespread Prepayment Review of Claims for Power Mobility Devices (HCPCS K0823 and All Related Accessories)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0823 and all related accessories. The fifth quarter edit effectiveness results from July 2012 through October 2012 are as follows:

The K0823 review involved 1,326 claims of which 1,217 were denied. This resulted in an overall error rate of 92%.

Historical Data of the Error Rate for K0823 Review



Primary Documentation Errors that Resulted in Denial of Claims

28% of K0823 claims received a denial as criteria C not met.

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

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

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

18% of K0823 claims received a denial as criteria B not met.

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

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

7% of K0823 claims received a denial as no or invalid detailed product description submitted.

- LCD L23598 states, "Once the supplier has determined the specific power mobility device that is appropriate for the patient based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description). This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-08) Chapter 5. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispensed is properly coded.
- The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the PWC or POV. A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request."

7% of K0823 claims received a denial as criteria A not met.

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

A. The patient 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 patient from accomplishing an MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the patient from completing an MRADL within a reasonable time frame.

Going Forward

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

Education Resources

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

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

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

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

Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)

MLN Matters® Number: SE1231

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

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

Power Operated Vehicles (POVs or scooters): Under the Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, or manually operated wheelchair. In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (Motorized) Wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

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

Background
The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare Fee-For-Service Program. CMS is conducting a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines **beginning with orders written on or after September 1, 2012.** The demonstration will be conducted in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. These States accounted for 43 percent of the $606 million total Medicare PMD expenditures in 2010. This demonstration targets a claim type known to be susceptible to fraud and that have high rates of improper payments.

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

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

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

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the

face-to-face encounter documentation, the 7 element order, the detailed product description and whatever additional documentation is necessary to show that coverage requirements have been met.

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

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

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 48 hours. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. **Claims with a non-affirmative prior authorization decision will not be paid by Medicare.**

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

Suppliers may choose to submit claims without a prior authorization decision; however, the claim will still be subject to prepayment review. Beginning for orders written on or after December 1, 2012, CMS will assess a payment reduction for noncompliance with the prior authorization process. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS competitive bidding program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

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

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

Key Points

CMS will initially conduct this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary address as reported to the Social Security Administration and recorded in Medicare's Common Working File (CWF). This demonstration will involve all four DME MACs. This demonstration will begin for orders written on or after September 1, 2012.

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

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

Additional Information

The Prior Authorization of Power Mobility Device Section of the CMS webpage is at http://Go.cms.gov/PADemo.

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

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

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

Revised – K0009 Manual Wheelchair – Coding Verification Review Requirement

Previously it was communicated that Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) products listed on the PDAC website with HCPCS code K0009 (OTHER MANUAL WHEELCHAIR/BASE) will be end dated effective September 30, 2012. This effective date has been changed. The new effective date will now be February 28, 2013. Manufacturers will still be required to submit a new coding verification application to the PDAC for review and assignment of the correct code for products currently coded as K0009.

Effective for claims with dates of service on or after March 1, 2013, the only products which may be billed to Medicare using code K0009 are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification List in DMECS maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code A9270.

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

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

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

Current Review Results

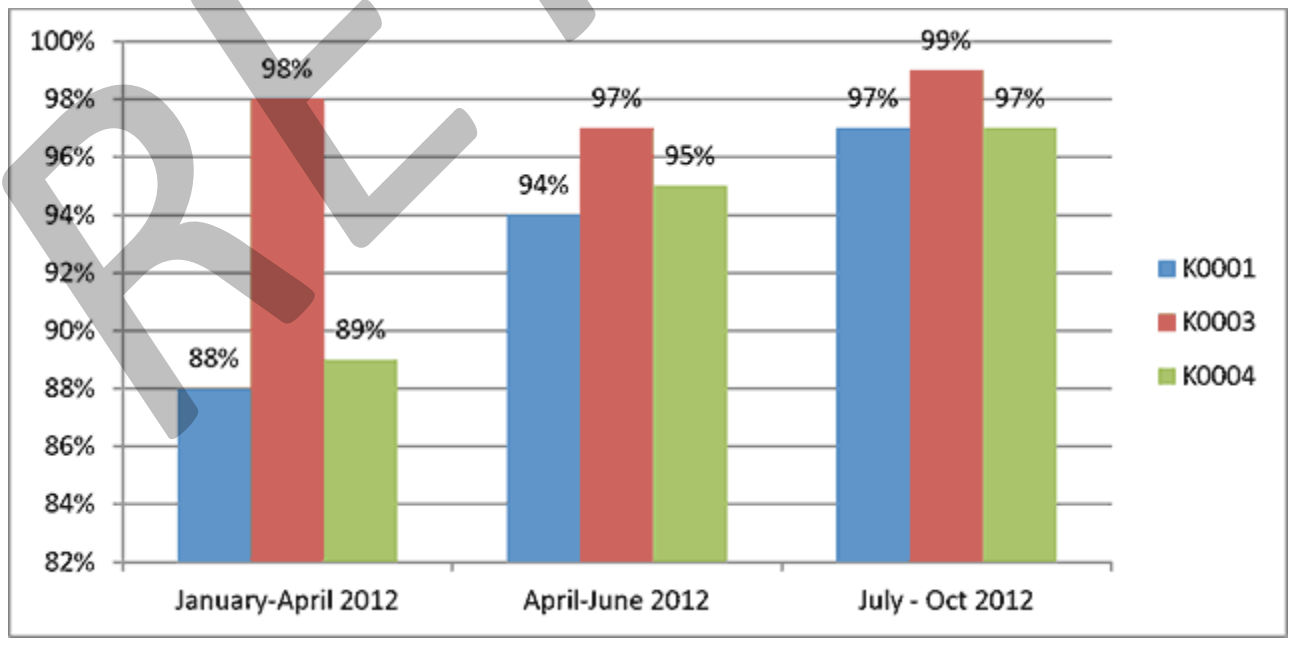
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes K0001, K0003 and K0004. The third quarter edit effectiveness results from July 2012 through October 2012 are as follows:

The K0001 review involved 627 claims of which 601 were denied. This resulted in an overall error rate of 97%.

The K0003 review involved 524 claims of which 517 were denied. This resulted in an overall error rate of 99%.

The K0004 review involved 407 claims of which 393 were denied. This resulted in an overall error rate of 97%.

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



Primary Documentation Errors that Resulted in Denial of Claims

- 21% of K0001 claims received a denial as criteria B not met.
- 17% of K0003 claims received a denial as criteria B not met.
- 18% of K0004 claims received a denial as criteria B not met.

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

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

- 19% of K0001 claims received a denial as criteria A not met.
- 16% of K0003 claims received a denial as criteria A not met.
- 17% of K0004 claims received a denial as criteria A not met.

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

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

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

- 13% of K0001 claims received a denial as criteria C not met.
- 9% of K0003 claims received a denial as criteria C not met.

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

A. 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.

- 12% of K0001 claims received a denial as criteria D not met.

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

B. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

- 9% of K0003 claims received a denial as no documentation received.
- 11% of K0004 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.

- 21% of K0003 claims received a denial as criteria 1 and 2 are not met for K0003.

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

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

- 21% of K0004 claims received a denial as criteria 1 and 2 are not met for K0004.

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

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

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

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

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

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

MOBILITY DEVICES CONT'D

NORIDIAN Administrative Services LLC

Medicare

Reissued September 2012

Power Wheelchairs and Power Operated Vehicles – Documentation Requirements

Dear Physician,

In order for Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several statutory requirements that must be met:

1. There must be an in-person visit with a physician specifically addressing the patient's mobility needs.
2. There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the patient's mobility limitation and needs. The results of this evaluation must be recorded in the patient's medical record.
3. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements (see below).
4. The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

The in-person visit and mobility evaluation together are often referred to as the "face-to-face examination".

The complete history and physical examination typically includes:

- History of the present condition(s) and past medical history that are relevant to the patient's mobility needs in the home:
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the patient can walk without stopping and with what assistive device, such as a cane or walker
  - Pace of ambulation
  - History of falls, including frequency, circumstances leading to falls, and why a walker isn't sufficient
  - What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn't sufficient
  - What has changed to now require use of a power mobility device
  - Ability to use a manual wheelchair
  - Reasons why a power operated vehicle (scooter) would not be sufficient for this patient's needs in the home
  - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to the patient's mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination
    - **If the patient is capable of walking, the report should include documented observation of ambulation (with use of a cane or walker, if appropriate)**

Examples of vague or subjective descriptions of the patient's mobility limitations include:

- "upper extremity weakness"
- "poor endurance"
- "gait instability"
- "weakness"
- "abnormality of gait"
- "difficulty walking"
- "SOB on exertion"
- "pain"
- "fatigue"
- "deconditioned"

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the **patient's** mobility deficits. Objective measurements should be provided.

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

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It is important to keep in mind that because of the way that the Social Security Act defines durable medical equipment, a power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home. If the wheelchair/POV is needed in the home, the beneficiary may also use it outside the home. However, in your evaluation you must clearly distinguish your patient's mobility needs within the home from their needs outside the home.

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

You should record the visit and mobility evaluation in your usual medical record-keeping format. Many suppliers provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not. That is because they typically contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the patient's ambulatory abilities and limitations to allow the Medicare contractor to determine if coverage criteria have been met . Forms such as those developed by the Texas or Florida Academy of Family Physicians are designed to gather selected bits of information and are almost always insufficient. What is required is a thorough narrative description of your patient's current condition, past history, and pertinent physical examination that clearly describes their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.

You may write a prescription for a power mobility device ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

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

You must forward a copy of the face-to-face evaluation and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of your patient's ambulatory problems.

After the supplier receives your order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, you should contact the supplier to clarify what you want the beneficiary to receive.

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination on Power Mobility Devices. It is only a synopsis detailing the highlights of documentation. Refer to the complete LCD and Policy Article on the CMS Web site at www.cms.hhs.gov/mcd/overview.asp for additional information.

Medicare does provide you additional reimbursement (HCPCS code G0372) to recognize the additional time and effort that are required to provide this documentation to the supplier. This code is payable in addition to the reimbursement for your E&M visit code.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

Paul J. Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A

Stacey V. Brennan, M.D., FAAFP
Medical Director, DME MAC, Jurisdiction B

Robert D. Hoover, Jr., MD, MPH, FACP Medical Director,
DME MAC, Jurisdiction C

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC, Jurisdiction D

CMS

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NEBULIZERS

Widespread Prepayment Review for Nebulizer Drugs – Edit Effectiveness for Fourth Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of nebulizer drugs with HCPCS codes J7626 and J7605 and the third quarter edit effectiveness results from June 2012 through August 2012 are as follows:

The results of the review, for item J7626, identified 2538 claims of which 1553 were denied. A total of 843 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 62%.

The results of the review, for item J7605, identified 1037 claims of which 586 were denied. A total of 305 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 57%.

Due to the error rate remaining high, NAS will continue with the widespread complex review for the above mentioned nebulizer drugs.

The following are the top reasons for denial:

a. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

b. No medical documentation provided to support the medical necessity for the billed items.

c. No beneficiary evidence of exhaustion submitted regarding refills.

d. No valid written order

- No written order submitted with the documentation
- Insufficient or incomplete order

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

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

b. 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.

c. The Program Integrity Manual chapter 5 section 5.2.6 states, "For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply."

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

   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 billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code

The order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for that solution. The type of solution is described by a combination of: (a) the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container, or (b) the name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizers Local Coverage Determination (LCD) L11488 and Policy Article A24942. Suppliers can also review the Nebulizer documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/checklists.html.

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

Widespread Prepayment Probe Review Results for Nebulizer Medication Q4074 and J7686

Jurisdiction D DME MAC Medical Review completed the widespread prepayment review of claims for nebulizer medications with HCPC codes Q4074 (iloprost) and J7686 (treprostinil). This review was initiated based on the results of the Comprehensive Error Rate Testing (CERT) review analysis.

The results of the review of the claims for iloprost, code Q4074, identified 101 claims of which 47 were denied. This results in an overall error ratio of 51%.

The results of the review of the claims for treprostinil, code J7686, identified 100 claims of which 46 were denied. This results in an overall error ratio of 46%.

DME MAC D will close these reviews for Q4074 (iloprost) and J7686 (treprostinil). By closing this file, medical review will no longer request documentation for the specified criteria.

Contractors are required to monitor the utilization patterns of suppliers and observe for medical necessity and appropriate coding practices. Claims will be subject to the routine claims processing system and edits that may suspend claims for review.

The following are the top reasons for denial:

a. No or invalid documentation supporting refill requirements
b. No documentation received
c. The documentation submitted did not support medical necessity
d. Proof of delivery was not submitted

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

a. Per LCD L11488, 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.

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

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

   - Beneficiary's name or authorized representative if different than the beneficiary
   - A description of each item that is being requested
   - Date of refill request
   - Quantity of each item that the beneficiary still has remaining

NEBULIZERS CONT'D

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.

b. 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.

c. Per LCD L11488, criteria 1–3 must be met:

   1. The patient has a diagnosis of pulmonary artery hypertension (ICD-9 diagnosis codes 416.0 or 416.8); and

   2. The pulmonary hypertension is not secondary to pulmonary venous hypertension (e.g., left sided atrial or ventricular disease, left sided valvular heart disease, etc) or disorders of the respiratory system (e.g., chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.); and

   3. The patient has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions: connective tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, anorexigens or congenital left to right shunts. If these conditions are present, the following criteria (a–d) must be met:

      a. The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition; and

      b. The mean pulmonary artery pressure is > 25 mm Hg at rest or > 30 mm Hg with exertion; and

      c. The patient has significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope); and

      d. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out.

d. Per publication 100-08, chapter 4, section 4.26–4.26.2 of the Medicare Program Integrity Manual, suppliers are required to maintain proof of delivery documentation in their files. Suppliers may deliver directly to the beneficiary or the designee, utilize a shipping service or mail order, or utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery.

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

- Nebulizers LCD L11488
- Nebulizers Policy Article A24942
- Medicare Program Integrity Manual Chapter 4
- DME MAC Jurisdiction D Supplier Manual

NOTIFICATION OF REVIEW

Notification of Osteogenesis Stimulators Prepayment Review

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

- E0747 – Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
- E0748 – Osteogenesis stimulator, electrical, noninvasive, spinal applications

This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for

HCPCS codes E0747 and E0748 are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied as not medically necessary. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) and related Policy Article for the HCPCS listed in this notification article:

- Osteogenesis Stimulators L11490 & A35423

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

Notification of Prepayment Review for Lower Limb Prostheses HCPCS Codes

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

- L5673 – Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
- L5301 – Below knee, molded socket, shin, sach foot, endoskeletal system
- This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) and related Policy Article for the HCPCS listed in this notification article:

- Lower Limb Prostheses L11453 & A25367

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

Notification of Prepayment Review for Oral Anticancer Drugs

NAS Jurisdiction D DME MAC Medical Review will be initiating a widespread prepayment probe review of claims for the following oral anticancer drugs:

- Capecitabine 150 mg and/or 500 mg
- Temozolomide 5 mg and/or 20 mg

This review is being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for the oral anticancer drugs listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item(s) billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 45 days of the date on the letter will result in the claim being denied. The ADR letter will provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Local Coverage Determination (LCD) and related Policy Article for the oral anticancer drugs listed in this notification article:

- Oral Anticancer Drugs L11574 and A25372

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

OVERPAYMENTS/REFUNDS

Refunds to Medicare

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

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

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

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

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

OXYGEN

Coverage Reminder – Testing for Oxygen and Oxygen Equipment Coverage

Coverage for oxygen and oxygen equipment is dependent upon the presence of conditions that cause chronic hypoxemia. When the underlying condition is in the chronic stable state, blood oxygen testing may be performed by a qualified provider of laboratory services to evaluate the degree of hypoxemia. This result is used to assess eligibility for Medicare reimbursement for oxygen and oxygen equipment. This article serves to summarize essential information regarding oxygen testing.

There are two types of tests that may be used to assess the beneficiary. Acceptable tests are:

- Arterial Blood Gas (ABG) testing – direct testing of oxygen content from an arterial blood sample
- Oximetry – also known as "spot" or "pulse" oximetry involves the determination of percent (%) oxygen saturation via a transcutaneous sensor. There are three types of oximetry testing used for qualification for payment:
  - At rest oximetry
  - Overnight oximetry
  - Exercise oximetry

For purposes of oxygen reimbursement, all testing must be performed as a stand-alone test and not as a part of a more extensive or complex test such as home sleep testing for obstructive sleep apnea or cardiac stress testing. A single exception exists for titration polysomnography. Refer to BOTH the Positive Airway Pressure Devices and Oxygen and Oxygen Equipment policies for additional information about this testing scenario.

For purposes of oxygen reimbursement, all testing must be performed by a qualified provider of laboratory services and be directly supervised by medical personnel qualified to perform the test. A single exception exists for home overnight oximetry. Refer to the Oxygen and Oxygen Equipment policy for additional information about this testing scenario.

Exercise oximetry requires that three (3) oximetry values be obtained during the same testing session. The three requires tests are:

- At rest oximetry on room air showing a non-qualifying result
- Oximetry while exercising on room air showing a qualifying result
- Oximetry while exercising on oxygen showing an improvement in the hypoxemia identified while exercising on room air

Oximetry obtained after exercise while resting, sometimes referred to as "recovery" testing, is not part of the three required test elements for exercise testing and is not valid for determining eligibility for oxygen coverage. For billing purposes, the test result obtained while exercising on room air should be reported on the Certificate of Medical Necessity (CMN).

Testing for oxygen qualification is associated with two additional requirements, which must be met in order for the testing to be acceptable for reimbursement. These requirements are:

- Timing of the test
  - For all oxygen groups (i.e., Group I, II and III), initial testing must be done within the 30 days before the initial date of service
  - For Group II beneficiaries, recertification testing must be done between day 61 – 90 after the initial date of service
- Treating physician visit
  - For all oxygen groups (i.e., Group I, II and III), for the initial testing, a physician visit must be done within the 30 days before the initial date of service
  - For all recertification's, a physician visit must be done within 90 days before the recertification date

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

First Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment billed with 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 first quarter edit effectiveness results from June 2012 through September 2012 are as follows:

The E0439 (RA) review involved 38 claims of which 27 were denied. This resulted in an overall error rate of 70%.

The E0434 (RA) review involved 39 claims of which 29 were denied. This resulted in an overall error rate of 74%.

Primary Documentation Errors that Resulted in Denial of Claims

- 18% of E0439 (RA) claims received a denial as no documentation was received
- 46% 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.

- 18% of E0439 (RA) claims received a denial as no medical documentation was submitted to support the blood gas study documented on the CMN.
- 9% of E0434 (RA) claims received a denial as no medical documentation was submitted to support the blood gas study documented on the CMN.

For certification for replacement equipment, repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.

If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record. However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. *There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable)* or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

- 12% of E0439 (RA) claims received a denial as the documentation submitted did not support continued need of the oxygen and oxygen equipment.
- 11% of E0434 (RA) claims received a denial as the documentation submitted did not support continued need of the oxygen and oxygen equipment.

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

For DMEPOS items for which there is on-going use, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continued to remain reasonable and necessary. Information used to justify this continued need must be timely for the DOS under review.

- 13% of E439 (RA) claims received a d enial as the documentation submitted did not support continued use of the oxygen and oxygen equipment.
- 6% of E0434 (RA) claims received a denial as the documentation submitted did not support continued use of the oxygen and oxygen equipment.

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.

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

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

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

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

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

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

Current Review Results
The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes E1390 and E0431 billed with the RA modifier. The first quarter edit effectiveness results from May 2012 through August 2012 are as follows:

The E1390 (with the RA modifier) review involved 46 claims of which 33 were denied. This resulted in an overall error rate of 75%.

The E0431 (with the RA modifier) review involved 30 claims of which 24 were denied. This resulted in an overall error rate of 81%.

Primary Documentation Errors that Resulted in Denial of Claims

- 25.71% of E1390 (RA) claims received a denial as the documentation submitted did not support continued use of the oxygen and oxygen equipment.
- 26.76% of E0431 (RA) claims received a denial as the documentation submitted did not support continued use of the oxygen and oxygen equipment.

OXYGEN CONT'D

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.

- 21.90% of E1390 (RA) claims received a denial as the documentation submitted did not support continued need of the oxygen and oxygen equipment.
- 21.13% of E0431 (RA) claims received a denial as the documentation submitted did not support continued need of the oxygen and oxygen equipment.

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

For DMEPOS items for which there is on-going use, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continued to remain reasonable and necessary. Information used to justify this continued need must be timely for the DOS under review.

- 15.24% of E1390 (RA) claims received a denial as no medical documentation was received to support that the blood gas study was obtained while the patient was in a chronic stable state.
- 8.45% of E0431 (RA) claims received a denial as no medical documentation was received to support that the blood gas study was obtained while the patient was in a chronic stable state.

The qualifying blood gas study must be obtained under one of 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.

If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease.

- 14.29% of E1390 (RA) claims received a denial as no documentation was received.
- 7.04% of E1390 (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.

- 8.57% of E1390 (RA) claims received a denial as no medical documentation was submitted to support the blood gas study documented on the CMN.
- 9.86% of E0431 (RA) claims received a denial as no medical documentation was submitted to support the blood gas study documented on the CMN.

For certification for replacement equipment, repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.

If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record. However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. *There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable)* or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

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

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

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

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

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

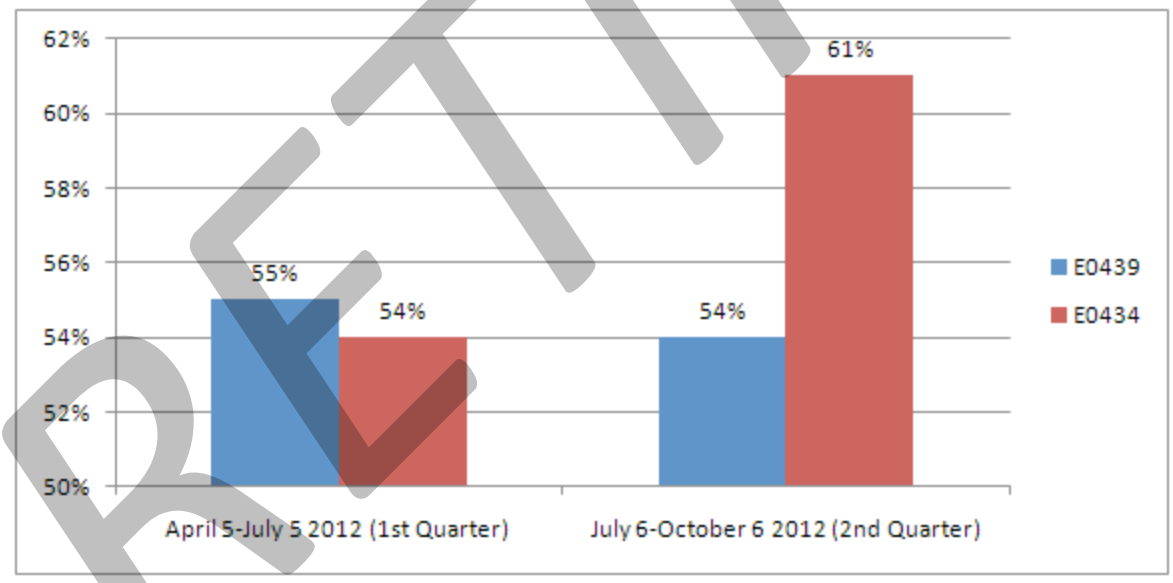
Second Quarter Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS E0439 and E0434)

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

The E0439 review involved 382 claims of which 196 were denied. This resulted in an overall error rate of 54%.

The E0434 review involved 224 claims of which 143 were denied. This resulted in an overall error rate of 61%.

Historical Data of the Error Rate for E0439 and E0434 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 19% of E0439 claims received a denial as no medical documentation was provided to support that the patient was seen and evaluated by the treating physician within 30 days prior to the date of initial certification.
- 19% of E0434 claims received a denial as no medical documentation was provided to support that the patient was seen and evaluated by the treating physician within 30 days prior to the date of initial certification.

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

OXYGEN CONT'D

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 fist 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.)

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

- 13% of E0439 claims received a denial as no medical documentation was received to support that the blood gas study was obtained while the patient was in a chronic stable state.
- 12% of E0434 claims received a denial as no medical documentation was received to support that the blood gas study was obtained while the patient was in a chronic stable state.

The qualifying blood gas study must be obtained under one of 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.
- If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease.
- 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.
- 11% 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.

- 10% 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.

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

OXYGEN CONT'D

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

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

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

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

PAP DEVICES

Widespread Prepayment Service Specific Targeted Review Edit Effectiveness for First Quarter for Continuous Positive Airway Pressure Devices (E0601)

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread service specific prepayment complex review for Continuous Positive Airway Pressure Devices (E0601) for the first month of billing (KH modifier) and the 4th thru 13th month of billing (KJ modifier). The 1st quarter edit effectiveness results from April 2012 through July 2012 are as follows:

The results of the review, for the KH modifier claims, identified 412 claims of which 223 were denied. This resulted in an overall error rate of 53%.

The results of the review, for the KJ modifier claims, identified 631 claims of which 386 were denied. This resulted in an overall error rate of 61%.

The following are the top reasons for denial for KH claims:

a. No documentation supporting a face-to-face evaluation prior to the sleep test to assess for obstructive sleep apnea (Criteria A of LCD L171)
b. No Medicare-covered sleep test that met criteria 1 or 2 (Criteria B of LCD L171)
c. No face-to-face evaluation prior to the sleep test to assess for obstructive sleep apnea (Criteria A of LCD L171)
d. Signature requirements not met per PIM 3.3.2.4

The following are the top reasons for denial for KJ claims:

a. No documentation supporting a face-to-face evaluation prior to the sleep test to assess for obstructive sleep apnea (Criteria A of LCD L171)
b. Documentation did not support that symptoms of obstructive sleep apnea are improved (Criteria 1 of Continued Coverage Beyond the First 3 Months of Therapy)
c. There was no objective evidence of adherence to use of the PAP device reviewed by the treating physician (Criteria 2 of Continued Coverage Beyond the First 3 Months of Therapy)
d. No Medicare-covered sleep test that met criteria 1 or 2 (Criteria B per LCD L171)
e. Signature requirements not met per PIM 3.3.2.4

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

a. There were a number of claims that were submitted without an initial face-to-face evaluation or the documentation provided did not contain information regarding symptoms of suspected obstructive sleep apnea.In regards to the initial face-to-face clinical evaluation prior to the sleep test to assess for obstructive sleep apnea (criteria A) per LCD L171:

Physicians shall document the face-to-face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format that they use for other entries. For the initial evaluation, the report would commonly document pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History:

- Signs and symptoms of sleep disordered breathing including, snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
- Duration of symptoms
- Validate sleep hygiene inventory such as the Epworth Sleepiness Scale

Physical Exam:

- Focused cardiopulmonary and upper airway system evaluation
- Neck circumference
- Body mass index (BMI)

b. There were a number of claims that were submitted without Documentation of a qualifying sleep test per Medicare coverage guidelines.

The patient must have had a Medicare-covered sleep test that meets either of the following criteria (1 or 2):

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
   a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
   a. Hypertension, ischemic heart disease, or history of stroke.

c. There were a number of claims that were submitted without documentation of beneficiary instruction on use of CPAP machine.

In regards to the initial instruction to beneficiary (criteria C) per LCD L171:
The patient and/or their caregiver has received instruction from the supplier of the device in the proper use and care of the equipment.

d. There were a number of claims that were submitted without proper authentication of the sleep test or face-to-face visit.

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

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

a. There were a number of claims that were submitted without an initial face-to-face evaluation or the documentation provided did not contain information regarding symptoms of suspected obstructive sleep apnea.

In regards to the initial face-to-face clinical evaluation prior to the sleep test to assess for obstructive sleep apnea (criteria A) per LCD L171:

Physicians shall document the face-to-face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format that they use for other entries. For the initial evaluation, the report would commonly document pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History:

- Signs and symptoms of sleep disordered breathing including, snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
- Duration of symptoms
- Validate sleep hygiene inventory such as the Epworth Sleepiness Scale

Physical Exam:

- Focused cardiopulmonary and upper airway system evaluation
- Neck circumference
- Body mass index (BMI)

b. There were a number of claims that were submitted without a re-evaluation face-to-face between the 31st and 91st day with documentation that symptoms of obstructive sleep apnea are improved.

In regards to the re-evaluation face-to-face per LCD L171:
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.

c. There were a number of claims that were submitted without an objective adherence report.

In regards to the Adherence report per LCD L171:
Objective evidence of adherence to use of the PAP device reviewed by the treating physician. Adherence to therapy is defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

d. There were a number of claims that were submitted without Documentation of a qualifying sleep test per Medicare coverage guidelines.

The patient must have had a Medicare-covered sleep test that meets either of the following criteria (1 or 2):

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,

2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:

   a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,

   b. Hypertension, ischemic heart disease, or history of stroke.

There were a number of claims that were submitted without proper authentication of sleep tests and face-to-face visits.

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

100% of claims submitted with a Home Sleep Test were denied in both KH and KJ reviews for lack of HST instruction specific to the beneficiary of the claim. As a reminder, the Local Coverage Determination (LCD) Continuous Positive Airway Pressure Devices (L171) states in part: "For all PAP devices, beneficiaries who undergo an HST must, prior to having the test, receive instruction on how to properly apply a portable sleep monitoring device. This instruction must be provided by the entity conducting the HST and may not be performed by a DME supplier. Patient instruction may be accomplished by either:

Face-to-face demonstration of the portable sleep monitoring device's application and use; or,

Video or telephonic instruction, with 24 hour availability of qualified personnel to answer questions or troubleshoot issues with the device."

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

PAP DEVICES CONT'D

Determination (LCD) L171 and Policy Article A19827. Suppliers can also review the PAP devices resources and publications on the NAS website at https://www.noridianmedicare.com/dme/news/pap_devices.html

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

PRESSURE REDUCING SUPPORT SURFACES

Widespread Prepayment Review for E0181 Group 1 Pressure Relieving Support Surfaces – Edit Effectiveness for First Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0181 and the first quarter edit effectiveness results from April 27, 2012, through July 26, 2012, are as follows:

The results of the review, for item E0181, identified 69 claims of which 50 were denied. No claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 74%. Total dollars allowed were $503.16; total dollars denied were $1,410.99.

Due to the high error rate, NAS will continue with the widespread complex review for the E0181.

The following are the top reasons for denial:

- Criteria 1, 2, and or 3 of LCD L11578 were not met.
- Conditions A-D not met for criteria 2 and 3 of LCD L11578.
- No office or medical records provided.
- Documentation submitted does not support medical necessity for the item requested.

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

a. Per LCD L11578, A group 1 mattress overlay or mattress is covered if one of the following three criteria is met:

1. The patient is completely immobile – i.e., patient cannot make changes in body position without assistance, or
2. The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D below.

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

a. Impaired nutritional status
b. Fecal or urinary incontinence
c. Altered sensory perception
d. Compromised circulatory status

b. Per LCD L11578, 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.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces Group 1 LCD L11578 and Policy Article A33678 and Supplier's Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html.

Widespread Prepayment Review for E0185 Group 1 Pressure Relieving Support Surface – Edit Effectiveness for First Quarter

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code E0185. The 1st quarter edit effectiveness results from May 3, 2012, through August 2, 2012, are as follows:

The results of the review, for item E0185, identified 35 claims of which 24 were denied. No claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 69%. Total dollars allowed were $3,188.22; total dollars denied were $7,118.00.

Due to the high error rate, NAS will continue with the widespread complex review for the E0185.

The following are the top reasons for denial:

- Criterion 1, 2, and or 3 of LCD L11578 were not met.
- Conditions A-D for criterion 2 and 3 of LCD L11578 were not met.
- No written or verbal order received.
- No office notes/ medical records provided.

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

a. Per LCD L11578, A group 1 mattress overlay or mattress is covered if one of the following three criteria are met:

1. The patient is completely immobile – i.e. , patient cannot make changes in body position without assistance, or
2. The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D below.

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

a. Impaired nutritional status
b. Fecal or urinary incontinence
c. Altered sensory perception
d. Compromised circulatory status

b. Per Policy Article A33678, For an item addressed in this policy to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained.

c. Per LCD L11578, 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.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters, as outlined in the Pressure Reducing Support Surfaces Group 1 LCD L11578 and Policy Article A33678 and Supplier's Manual Chapter 3: https://www.noridianmedicare.com/dme/news/manual/chapter3.html.

REFILLS

Consumable Supplies - Request for Refill Documentation Requirements

The Durable Medical Equipment Medicare Administrative Contractors have been conducting reviews on claims for consumable supplies. One of the top reasons for denials has been request for refill documentation. The most common errors involve how suppliers are documenting the quantity of an item the beneficiary has remaining.

For consumable supplies, i.e. those that are used up (e.g., ostomy, urological supplies, surgical dressings, or glucose supplies etc.) the supplier must sufficiently assess the quantity of each item that the beneficiary still has on hand, to determine that the amount remaining will be nearly exhausted. The following are some examples (not all-inclusive) of documentation that is not sufficient to justify reimbursement:

- "Yes" or "No" questions only regarding whether the beneficiary wants or needs more supplies.
- Documentation which only provides information regarding the amount of supplies the beneficiary is requesting.
- Documentation which only states that the beneficiary has less than the required threshold number of supplies left, e.g., Mrs. J stated that she has less than 14 days of glucose strips left.

Vague or nonspecific references to the quantity remaining are not sufficient to demonstrate compliance with the requirement that refills be provided when the current supply on hand is "approaching exhaustion". There must be an individualized and detailed record that quantifies the beneficiary's remaining supplies. An actual count is recommended but not necessary, but the record should evidence that an individual assessment has been performed. Note that a quantitative or semi-quantitative assessment actually performed individually for each refill would not have identical language in the record for each subsequent refill for the same beneficiary. Likewise, identical language for different beneficiaries would raise suspicions about whether individual assessments were actually performed.

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

For more information regarding these items and their requirements, refer to the local coverage determination and policy articles, supplier manual, and the standard documentation language articles.

FAQ – Refill Requirements for Non-consumable Supplies

In 2011, CMS added sections to the Program Integrity Manual (Internet Only Manual 100-8) Chapter 5 establishing the requirements for the provision of refills of supplies effective 8/2/2011. The DME MACs published a bulletin article announcing these new requirements along with guidance for documenting compliance. These requirements are applicable to all DMEPOS items and supplies provided on a recurring basis.

A key element of these requirements is the supplier's responsibility to monitor utilization of supplies and only provide a refill when the beneficiary's supply on hand is "approaching exhaustion". Given the range of products affected by this requirement, numerous inquiries were received asking for specifics about how to assess for this criterion. In June 2012, a revised bulletin was published by the DME MACs with documentation guidance to address this issue.

This FAQ addresses questions about the June 2012 bulletin.

Q1. Why separate consumable items from more durable ones?
A. Separating consumable from non-consumable supplies was based on calls from suppliers and inquiries received from our respective Provider Outreach and Education representatives at webinars and seminars. Specifically suppliers were asking, in light of the refill requirements in the LCD requiring suppliers to determine "…existing supplies are approaching exhaustion", how should suppliers document "approaching exhaustion" for items that are "used up" (e.g., diabetic test strips) versus items that are no longer functional (e.g., PAP and RAD supplies). Based on the questions, it made sense to segregate those two types of items in the documentation section.

Q2. Some DME items like infusion pumps and enteral and parenteral nutrition pumps also have non-consumable items as supplies. What items are considered to be durable or non-consumable supplies?
A. Supplies used with RAD and PAP devices and mastectomy bras were the initial supply items identified as non-consumable or durable and not requiring routine, scheduled replacement. Some items such as external infusion pumps or enteral and parenteral nutrition pumps have supplies provided in all-inclusive supply kit allowances. These supply kit allowances are considered payable as noted in the applicable local coverage determinations (LCDs) to cover all costs of supplies necessary for effective use of the base product.

REFILLS CONT'D

Q3. Why is it necessary to monitor utilization for durable supplies?
A. The DMDs recognize that providers of durable or non-consumable supplies are not accustomed to monitoring the utilization and condition of these items; however, the Program Integrity Manual (PIM) §5.2.6 refill requirements preclude the automatic dispensing (refill) of any supply item. All items and supplies provided on a recurring basis must be monitored and only replaced when replacement is genuinely needed.

Q4. Why are the documentation guidelines for non-consumable items so vague?
A. We understand that many suppliers would prefer explicit, prescribed instructions. The DMDs deliberately did not provide specific guidance as to how a supplier might assess the need for replacement of non-consumable supplies leaving as much flexibility to the supplier's discretion as possible. The PIM §5.2.6 refill requirement requires a determination that the need for the refill is justified. Recognizing that there are differing products and business practices, allowing each supplier to decide how to best assess and document the need for replacement was the most appropriate course.

Q5. Explain what is meant by the term "non-functional".
A. For purposes of this requirement, non-functional means that the item is no longer able to be used safely or effectively for the purpose for which it was intended. There are numerous reasons that would render durable supplies non-functional. Breakage, wear, or contamination (not all-inclusive) are some common examples. When the item becomes unusable for reasons such as damage, wear, soiling or contamination that is unable to be removed with recommended cleaning, etc., the item can be considered as nonfunctional andmay be replaced. All problems with the proper function of an item may not justify replacement (refill) of the item. For example, contrast the above situations with problems with function caused by improper fit or incorrect use such as might occur with a CPAP mask leak. Mask leak may be due to a non-functioning mask OR an ill-fitting or incorrectly worn interface. The latter would not necessitate replacement but rather reassessment of fit and possible adjustment by the physician or supplier.

Q6. What about maintenance or care for the item?
A. Appropriate replacement (refill) assumes reasonable effort to maintain the items per the manufacturer's instructions. With basic care these items remain useable and uncontaminated for extended periods. For example, we all recognize that improper or neglected care can render items dirty and contaminated; however, the solution is proper care and cleaning, not frequent replacement. As noted above, when the item becomes unusable for reasons such as damage, wear, soiling or contamination that is unable to be removed with recommended cleaning, etc., the item can be considered as nonfunctional andmay be replaced.

Q7. What is the effective date of the revision? The article says 8/2/11 – is this retroactive?
A. The documentation guidance is effective 8/2/11. These clarifications are not new requirements but simply provide additional explanations of the existing requirements that were published in August 2011, concurrent with the PIM §5.2.6 addition. This PIM section makes no distinction between supplies that are "used up" and those that are not. The PIM requires an assessment of whether or not supplies are "approaching exhaustion" and requires that suppliers not automatically ship new supplies. The June 2012 bulletin revision is an explanation of how to apply the existing "approaching exhaustion" requirement to non-consumable items.

Q8. Why are so many new requirements being published?
A. As part of our error reduction strategies, the DME MAC Medical Directors have begun including explicit statements about long-standing Medicare payment rules in many policies. Previously these requirements were only found in our DME MAC Supplier Manual and/or in CMS publications. Lack of familiarity with these requirements often leads to complaints that "new" and "more restrictive" rules have been put in place when the only thing new is a heightened awareness of the existing applicable payment policy. The refill guidance is one example of this.

Q9. Must the supplier physically inspect the item?
A. It depends on the problem reported. Some issues may require physical inspection by the supplier while others may be resolved through instructions to the beneficiary for adjustment or other accommodations.

Q10. Can the cleanliness state of the item be a reason to deem it non-functional (patient has not followed cleaning instructions and the part is now questionable from a health standpoint, even with a thorough cleaning)?
A. Yes, once the supplier determines that the item is no longer functional. Suppliers are reminded that they are responsible for instructing the beneficiary in the proper cleaning and care of the equipment and supplies.

Q11. What documentation must be created to ensure that the claim would pass an audit?
A. Document the reason(s) the item is no longer functional.

Q12. How does this revision affect the provision of a three-month supply?
A. Non-consumable supplies may be replaced when they are non-functional. The usual maximums listed in the LCD should not be construed as a routine or automatic replacement schedule or amount. If an item is still working and in good condition, there is no need to replace it. For example, many of the accessories/supplies used with positive airway pressure (PAP) devices do not require routine replacement at the "usual maximum" frequency listed in the LCD if cleaned and maintained according to the manufacturer's recommendations. Suppliers are required to confirm and document the amount and condition of supplies before sending out replacements.

Q13. Does this bulletin change the utilization guidelines in the LCD?
A. The guidance does not change the usual maximums or the replacement frequencies outlined in the LCD. It simply reiterates what has been published in the past by the DME MACs and CMS about replacements. Replacement is not automatic and suppliers need to assess and document the quantity and/or condition of the remaining supply. If it's something used up, ask how much is left. If it's something that can stop working effectively, ask about those common things that indicate it's not working effectively.

Q14. Under this provision, if the item becomes dysfunctional PRIOR TO the old "replacement schedule," will the replacement part be covered?
A. It may be. As noted in the questions above, assuming the non-functional status is not due to a correctable issue (e.g., fitting, adjustment, improper use), when a durable supply becomes non-functional, it is eligible to be replaced. If this results in exceeding the usual maximum allowable outlined in the LCD, suppliers should have sufficient documentation to explain why the amount exceeds the usual maximum supplies.

Q15. During the trial period, it is not unusual for a patient to need a different mask after trying one and it being "dysfunctional." Will Medicare pay for a new mask under this condition?
A. No. The mask is still functional, just not appropriate for that patient. It is a long-held position that Medicare will only pay for a replacement when the item is non-functional.

Items Provided on a Recurring Basis and Request for Refill Requirements - Revised - August 2012

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. CMS has revised the requirements for refills effective for dates of service on or after August 2, 2011.

August 2012 Revision
This revision updates the original article. Changed:

Revision of the Billing Frequency section to restore historical billing frequency for drugs and supplies used with external infusion pumps, including external insulin pumps.

June 2012 Revision
This revision updates the original article. Changes include:

Revised refill documentation instructions regarding consumable and non-consumable supplies

Addition of External Breast Prosthesis LCD to the list of included policies

Requirements
For all DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use.

REFILLS CONT'D

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

For all DMEPOS items 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- or three-month quantity at a time. See below for billing frequencies.

Documentation Requirements
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 patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

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

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

Billing Frequencies
For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous
The Local Coverage Determinations affected by these requirements will be updated in a future revision. The following policies are subject to these requirements:

REFILLS CONT'D

- Automatic External Defibrillators
- Enteral Nutrition
- External Breast Prosthesis
- External Infusion Pumps
- Glucose Monitors
- Immunosuppressive Drugs
- Intravenous Immune Globulin
- Nebulizers
- Negative Pressure Wound Therapy
- Oral Anticancer Drugs
- Oral Antiemetic Drugs
- Ostomy Supplies
- Oxygen (for billable contents)
- Parenteral Nutrition
- Positive Airway Pressure Devices
- Respiratory Assist Devices
- Suction Pumps
- Surgical Dressings
- Tracheostomy Supplies
- Transcutaneous Electrical Nerve Stimulator (TENS)
- Urologic Supplies

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

This August 2012 revision replaces the June 2012 revision of the original article. The original article, published August 2011, replaces the articles "Request for Refill - Documentation Requirements," published in September 2010 and "Dispensing DMEPOS Items: Quantity Limits" published in June 2007.

The June 2012 revision replaces the version published in August 2011.

For additional information, refer to CMS' Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, and the applicable Local Coverage Determinations and the Supplier Manual.

REMITTANCE ADVICE

Electronic Remittance Advice Formatting Concerns

The Centers for Medicare & Medicaid Services (CMS) issued a Medicare Learning Network Matters article 7499, titled "Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number"; the implementation date for supplier submitted claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) was October 1, 2012.

CMS determined that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) and that would subsequently reduce the costs for providers as well as Medicare.

Since the implementation of this change the DME MACs have received calls from suppliers who indicate their electronic remittance advices (ERAs) are not formatting correctly. On October 8, 2012 the Common Electronic Data

Interchange (CEDI) sent a reminder to the supplier community to upgrade to the 3.3 version of Medicare Remit Easy Print (MREP) so their ERAs will format correctly.

If you are a DMEPOS supplier who is encountering this problem, you should be aware that this is not a DME MAC issue but rather an issue with supplier software. Suppliers should contact their software vendors or clearinghouses to have their software updated as soon as possible so that their remits will format properly.

Note: If you received an ERA that was not properly formatted because your software was not updated, once updated suppliers can simply reprint the ERA. There is no need to contact the DME MACs.

This does not apply to suppliers who continue to receive standard paper remits.

This information was originally produced by Jurisdiction B.

Revision of Medicare Summary Notice for Non-Competitive Bid Claims

MLN Matters® Number: MM7729 Revised
Related Change Request (CR) #: CR 7729
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R1110OTN
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Note: This article was revised on August 7, 2012, to reflect the revised CR7729 released on August 3, 2012. In the article, the CR release date, transmittal number and the Web address for accessing CR7729 have been revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Non-Competitive Bidding Areas.

Provider Action Needed
This article is based on Change Request (CR) 7729 which corrects Medicare Summary Notice (MSN) message (MSN 16.07) incorrectly displaying on MSNs for non-competitive bid claims.

CR7729 instructs your Medicare contractor to use MSN message 16.71 (as follows) for beneficiary submitted non-National Competitive Bidding (non-NCB) related claims: Your provider must complete and submit your claim. In addition, CR7729 instructs your Medicare contractor to use MSN 16.07 (as follows) for beneficiary submitted NCB-related claims (per CR7066): Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program.

Background
The Medicare Summary Notices (MSN) is the primary vehicle by which beneficiaries are notified of decisions on their claims for Medicare benefits. Medicare contractors mail a single MSN at the end of the month to each beneficiary for whom a claim was processed during the month to inform the beneficiary of the disposition of their claims. The contractors issue No-Pay MSNs on a quarterly/90 day mailing cycle, and MSNs with checks (to the beneficiary) are mailed out as processed.

The Centers for Medicare & Medicaid Services (CMS) learned that a Durable Medical Equipment Prosthetic, Orthotic and Supplies (DMEPOS) National Competitive Bidding (NCB) MSN message, (MSN 16.07), is incorrectly displaying on MSNs for non-competitive bid claims.

MSN 16.07 currently reads "Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program". This language was established for beneficiary-submitted NCB claims, effective with the implementation of CR7066 (Transmittal 777, September 24, 2010, "Durable Medical Equipment (DME) National Competitive Bidding (NCB) Implementation - Phase 11E: Remittance Advice (RA) and Medicare Summary Notice (MSN) Messages for Round One." You can review CR7066 at http://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/downloads/R777OTN.pdf on the CMS website. Prior to the implementation of CR7066, MSN 16.07 read, "Your provider must complete and submit your claim."

REMITTANCE ADVICE CONT'D

In order to resolve the issue of the incorrect MSN being displayed, CR7729 instructs your Medicare contractor to:

- Use MSN message 16.71 for beneficiary submitted non-NCB related claims: Your provider must complete and submit your claim.
- Use MSN 16.07 for beneficiary submitted NCB- related claims(per CR7066). Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program.

Additional Information
The official instruction, CR7729, issued to your DME MACs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1110OTN.pdf on the CMS website.

SURGICAL DRESSINGS

Surgical Dressings – Benefit Category Reminder

Recently questions have arisen regarding the use of surgical dressings for Medicare beneficiaries. Surgical dressings are afforded limited coverage by Medicare as defined in the Centers for Medicare & Medicaid Services (CMS) Benefit Policy Manual (Internet-only Manual, Publ. 100-2). Chapter 15, Section 100 of the Benefit Policy Manual provides details for coverage of surgical dressings under this benefit:

Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound caused by, or treated by, a surgical procedure that has been performed by a physician or other health care professional to the extent permissible under State law. In addition, surgical dressings required after debridement of a wound are also covered, irrespective of the type of debridement, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of his/her legal authority when performing this function. Surgical dressings are covered for as long as they are medically necessary

Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings. Elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered as surgical dressings. Some items, such as transparent film, may be used as a primary or secondary dressing.

As a result of this restrictive language, not all wounds are eligible for surgical dressing reimbursement. To be eligible for coverage, at least one of the two following key statutory requirements must be met:

1. The wound must be surgically-created or surgically-modified; or,
2. The wound requires debridement.

The DME MAC Surgical Dressings Local Coverage Determination and related Policy Article provides additional examples of situations (not all-inclusive) in which dressings are statutorily excluded from coverage under the Surgical Dressings benefit:

a. Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or,
b. A Stage I pressure ulcer; or,
c. First degree burn; or,
d. Wounds caused by trauma which do not require surgical closure or debridement - e.g., skin tear or abrasion; or,
e. A venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle.

There must be sufficient information in the beneficiary's medical record regarding the wound(s) (e.g., etiology, size, depth, tunneling/undermining, exudate/escar characteristics, prior treatments) to allow the DME MAC's review staff to determine that the wound(s) meet the applicable statutory coverage criteria. In some instances, it may be clinically appropriate to utilize a particular dressing to treat a wound; however, unless the statutory benefit category requirements for surgical dressings described above are met, Medicare coverage for the surgical dressing is precluded. Claims for surgical dressings that do not meet the statutory benefit requirements will be denied as non-covered (no benefit).

Note that if the above statutorily-excluded dressings are billed to Medicare, they must have appended a GY modifier, indicating no Medicare benefit. This statutory exclusion and need for a GY modifier also applies to dressings used for similar situations such as abrasions, cuts, friction tears, ruptured bullae, self-inflicted wounds, "moisture-acquired skin defects" and similar wounds unless they are either (a) caused by or the result of a surgery or (b) documented in the record to have required surgical debridement.

Gradient compression stockings merit additional caution. According to CMS, gradient compression stockings that serve a therapeutic or protective function and that are needed to secure a primary dressing may be covered as surgical dressings. The gradient stocking must be proven to deliver compression greater than 30 mm Hg. and less than 50 mm Hg. In addition to these requirements, the basic benefit category requirement of use to treat a surgically-created or surgically-treated wound must still be met. Consequently, Medicare limits the coverage and reimbursement of gradient compression stockings to the following situation:

- The beneficiary must have an open venous stasis ulcer that **has been treated by a physician or other healthcare professional *requiring medically necessary debridement.*** [Emphasis added]

Additionally, CMS provides guidance on situations where gradient compression stockings are non-covered:

- Venous insufficiency without stasis ulcers
- Prevention of stasis ulcers
- Prevention of the reoccurrence of stasis ulcers that have healed
- Treatment of lymphedema in the absence of ulcers

When a covered gradient compression stocking is provided to a patient with an open venous stasis ulcer, the modifier AW (item furnished in conjunction with a surgical dressing) must be appended or the claim will be denied as a non-covered service.

Finally, note that many of the citations above reference documentation of treatment by the physician or other healthcare professional. Suppliers are reminded that the CMS Program Integrity Manual (Internet-only Manual, Chapter 5) in Section 5.7 states (in 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).

Suppliers should refer to the Surgical Dressings LCD and related Policy Article for additional coverage, coding and documentation requirements.

TENS

Conductive Garment for Delivery of TENS or NMES Prepayment Widespread Review – Second Quarter Edit Effectiveness

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of the TENS conductive garment with HCPCS code E0731. The second quarter edit effectiveness results from July 2012 through October 2012 are as follows:

The results of the review, for item E0731, identified 423 claims of which 409 were denied. A total of 326 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 98%.

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

The following are the top reasons for denial:

a. Medical documentation was not submitted.

b. The medical documentation does not support coverage of the garment purchase.

c. Proof of delivery was not submitted.

d. Medical documentation was either not submitted, or did not document usage, duration, and results.

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

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

B. Per LCD L11495, a conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but may be covered if all of the following conditions are met:

   1. It has been prescribed by a physician for use in delivering covered TENS treatment; and
   2. One of the medical indications outlined below is met:

      a. The patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or

      b. The patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; or

      c. The patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or

      d. The patient requires electrical stimulation beneath a cast to treat chronic intractable pain.

C. Per publication 100-08, chapter 4, section 4.26–4.26.2 of the Medicare Program Integrity Manual, suppliers are required to maintain proof of delivery documentation in their files. Suppliers may deliver directly to the beneficiary or the designee, utilize a shipping service or mail order, or utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery.

D. Per LCD L11495, a reevaluation of the beneficiary at the end of the trial period must indicate how often the beneficiary used the TENS unit, the typical duration of use each time, and the results (effectiveness of therapy).

It is important for suppliers to be familiar with the documentation requirements as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) LCD and policy article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

- Transcutaneous Electrical Nerve Stimulators (TENS) LCD L11495
- Transcutaneous Electrical Nerve Stimulators (TENS) Policy Article A37074
- Medicare Program Integrity Manual Chapter 4
- DME MAC Jurisdiction D Supplier Manual

Information about probe/error validation reviews may be found in the CMS Publication 100-08, Medicare Program Integrity Manual (PIM), Chapter 3.

Coverage Reminder – TENS Used For Chronic Low Back Pain

Effective for dates of service on or after June 8, 2012, Transcutaneous Electrical Nerve Stimulators (TENS) and related supplies used for chronic low back pain (CLBP) are only covered when the beneficiary is a participant in a CMS-approved clinical trial and has one or more required diagnoses. All other claims for TENS and related supplies used for CLBP will be denied as not reasonable and necessary. Only the following diagnoses (ICD-9) will justify coverage:

- 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 must be 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 DOCUMENTATION REQUIREMENTS and APPENDICES sections of TENS LCD for additional information about approved clinical studies.

Coverage requirements for TENS and related supplies used for non-CLBP remain unchanged. Refer to the INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY section of LCD for additional information about coverage for non-CLBP conditions.

Information concerning documentation required for TENS used for CLBP may be found in the LCD. Also Refer to the Supplier Manual for additional information about general documentation requirements.

TENS Device, Four or More Leads, Prepayment Widespread Review – Second Quarter Edit Effectiveness

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of Transcutaneous Electrical Nerve Stimulators (TENS) device, 4 or more leads, with HCPCS code E0730. The second quarter edit effectiveness results from July 2012 through October 2012 are as follows:

The results of the review, for item E0730, identified 217 claims of which 215 were denied. A total of 85 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 99%.

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

The following are the top reasons for denial:

a. Medical documentation was either not submitted to document or did not document why 2 leads are insufficient to meet the patient's needs.

b. Documentation was not submitted.

c. Medical documentation was either not submitted to document or did not document usage, duration, and results.

d. Medical documentation was either not submitted to document or did not document other appropriate treatment modalities that have been tried and failed.

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

a. Per LCD L11495, a TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the

patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patient's needs.

b. 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.

c. Per LCD L11495, a reevaluation of the beneficiary at the end of the trial period must indicate how often the beneficiary used the TENS unit, the typical duration of use each time, and the results (effectiveness of therapy).

d. Per LCD L11495, other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used.

It is important for suppliers to be familiar with the documentation requirements as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) LCD and policy article. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely.

- Transcutaneous Electrical Nerve Stimulators (TENS) LCD L11495
- Transcutaneous Electrical Nerve Stimulators (TENS) Policy Article A37074
- DME MAC Jurisdiction D Supplier Manual

Information about probe/error validation reviews may be found in the CMS Publication 100-08, Medicare Program Integrity Manual (PIM), Chapter 3.

Transcutaneous Electrical Nerve Stimulators Device, 2 Lead, Prepayment Widespread Review - First Quarter Edit Effectiveness

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of Transcutaneous Electrical Nerve Stimulators (TENS) device, 2 lead, with HCPCS code E0720. The first quarter edit effectiveness results from May 2012 through August 2012 are as follows:

The results of the review, for item E0720, identified 23 claims of which 22 were denied. A total of 5 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 95%.

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

The following are the top reasons for denial:

1. Medical documentation was either not submitted or did not support the TENS usage and frequency.
2. The CMN was invalid.
3. Medical documentation was either not submitted or did not document trial criteria.
4. Medical documentation was either not submitted or did not document other appropriate treatment modalities that have been tried and failed.

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

1. Per LCD L11495, the physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.
2. Per LCD L11495, for a purchased TENS unit, a Certificate of Medical Necessity (CMN), which has been completed, signed and dated by the treating physician, must be kept on file by the supplier and made available upon request.
3. Per LCD L11495, when used for the treatment of chronic, intractable pain, the TENS unit must be used by the patient on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.

4. Per LCD L11495, other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

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

Transcutaneous Electrical Nerve Stimulation for Chronic Low Back Pain

MLN Matters® Number: MM7836
Related Change Request (CR) #: CR 7836
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R2511CP and R144NCD
Effective Date: June 8, 2012
Implementation Date: January 7, 2013

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare contractors (carriers, Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Transcutaneous Electrical Nerve Stimulation (TENS) services provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 7836 which informs providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is revising the coverage for TENS for Chronic Low Back Pain (CLBP) effective for claims with dates of service on or after June 8, 2012. See the Key Points section of this article for specific coverage rules and review the lists of ICD- 9 and ICD-10 codes attached to the official instruction CR7836.

Background
In 2010, the Therapeutic and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published a report finding TENS ineffective for CLBP. CMS internally initiated a new national coverage determination (NCD) after the AAN published report and reviewed all the available evidence on the use of TENS for the treatment of CLBP.

Medicare has four NCDs pertaining to various uses of TENS that were developed before the CMS adoption of an evidence based and publicly transparent paradigm for coverage decisions. Those four NCDs are:

- Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2);
- Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1);
- Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13); and
- Transcutaneous Electrical Nerve Stimulators (TENS) (280.13). Please note, section 280.13 has been removed from the NCD manual and incorporated into NCD 160.27

The evidentiary basis is unclear for historic coverage. TENS has been historically thought to relieve chronic pain but the current evidence base refutes this assertion when applied to TENS for CLBP. Since TENS falls within the durable medical equipment (DME) benefit, Medicare coverage results in purchase after a brief initial rental period, even if the patient soon develops a subsequent tolerance to the TENS effect.

Key Points
Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will only allow coverage of TENS for CLBP defined for this decision as pain for 3 months or longer and not a manifestation of a clearly defined and generally recognizable primary disease entity, when the patient is enrolled in an approved clinical study under coverage with evidence development (CED).

Note: CED coverage expires three years from the effective date of this CR, June 8, 2015.

Examples of clearly defined and recognizable primary disease entities: neurodegenerative (e.g. multiple sclerosis) disease, malignancy, or well-defined rheumatic disorders (except osteoarthritis).

TENS CONT'D

Medicare contractors will accept and process line items that include an appropriate TENS HCPCS code, at least one ICD-9 diagnosis code for CLBP (see list of ICD-9 codes attached to CR7836), and all of the following:

- Date of service on or after June 8, 2012;
- Modifiers KX and Q0;
- ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only);
- Condition code 30 - (for institutional claims only)
- An acceptable ICD-9 code; and
- An acceptable ICD-10 code upon implementation (see list of ICD-10 codes attached to CR7836).

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2511CP of CR7836 at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group Code CO;
- Claim Adjustment Reason Code B5 (Coverage/program guidelines were not met or were exceeded.); and
- Remittance Advice Remark Code N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Medicare will pay for allowed TENS for CLBP based on the DME fee schedule.
All of the following conditions must be met for coverage of TENS for CLBP: CLBP is defined as:

- An episode of low back pain that has persisted for three months or longer; and
- Is not the manifestation of a clearly defined and generally recognizable primary disease entity.

For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom. Certain systemic diseases, e.g. rheumatoid arthritis, multiple sclerosis etc, manifest many debilitating symptoms of which low back pain is not the primary focus. CMS believes that the appropriate management of these types of diseases is guided by a systematic strategy aimed at the underlying causes. While TENS may infrequently be used adjunctively in managing the symptoms of these diseases, it is clearly not the primary therapeutic approach.

The patient is enrolled in an approved clinical study that addresses one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.

1. Does the use of TENS provide a clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
2. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
3. Does the use of TENS provide a clinically meaningful reduction in other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R144NCD of CR7836. That transmittal is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R144NCD.pdf on the CMS website.

Additional Information
The official instruction, CR 7836, issued to your Medicare Carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the NCD Manual and it is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R144NCD.pdf on the CMS website. The other transmittal updates the "Medicare Claims Processing Manual" and it is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf on the CMS website.

THERAPEUTIC SHOES

Fourth Quarter Edit Effectiveness for Therapeutic Shoes Review

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes A5500. The fourth quarter edit effectiveness results from June 2012 through August 2012 are as follows:

This review identified 2,846 claims of which 2,635 were denied. A total of 760 claims were denied for no response to the additional documentation request. This resulted in an overall error rate of 94%. Due to this high error rate, NAS will continue with the widespread complex review.

The following are the top reasons for denial:

a. Criterion 2 was not met per Policy Article (PA) A37076

b. Criterion 3 was not met per PA A37076

c. Requested documentation was not provided within the allotted time frame as referenced in the Medicare guidelines

d. There was no documentation from the supplier to support an in-person visit at the time of delivery per Local Coverage Determination (LCD) L157 and PA A37076

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

A. There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

   a. Previous amputation of the other foot, or part of either foot, or

   b. History of previous foot ulceration of either foot, or

   c. History of pre-ulcerative calluses of either foot, or

   d. Peripheral neuropathy with evidence of callus formation of either foot, or

   e. Foot deformity of either foot, or

   f. Poor circulation in either foot;

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

g. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or

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

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

B. 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.**

C. 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.

D. There must be documentation from the supplier to support an in-person visit at the time of delivery. The supplier must conduct and document an in-person visit with the patient. The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076. Suppliers can also review the Therapeutic Shoes documentation checklist on the NAS website at https://www.noridianmedicare.com/dme/coverage/docs/checklists/therapeutic_shoes.pdf.

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 SYSTEMS

Results of Widespread Prepayment Probe Review of Vacuum Erection System (L7900)

Jurisdiction D DME MAC Medical Review completed the widespread prepayment probe review of claims for Vacuum Erection System with HCPC code L7900 (Male Vacuum Erection System). This review was initiated based on data analysis that identified changes in billing patterns.

The results of the review of the claims for vacuum erection system, code L7900, identified 99 claims that were developed for additional documentation. Of the 99 claims that were reviewed, 81 claims were denied. This resulted in an overall error rate of 89%. Based on the results of this prepayment review, NAS will close this probe review and begin a widespread targeted review on HCPC code L7900.

The following are the top reasons for denial:

a. Medical records submitted did not support the medical necessity for the item requested

b. Invalid proof of delivered

c. No documentation received

d. Proof of delivery not submitted

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

A. The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)."

B. The Supplier Manual, chapter 3 states, "In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim. If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim."

C. 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).

D. Per publication 100-08, chapter 4, section 4.26–4.26.2 of the Medicare Program Integrity Manual, suppliers are required to maintain proof of delivery documentation in their files. Suppliers may deliver directly to the beneficiary or the designee, utilize a shipping service or mail order, or utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery.

It is important for suppliers to be familiar with the documentation requirements as outlined in the Vacuum Erection Devices (L7900) Documentation Requirements. Please ensure when submitting additional documentation, that all supporting medical necessity documentation is provided. Supplier responses should also be submitted timely. The following references were used in the medical review of these claims:

- Diagnosis and Treatment of Impotence NCD 230.4
- CMS Publication 100-8, Medicare Program Integrity Manual (PIM)
- DME MAC Jurisdiction D Supplier Manual

VERSION 5010

Version 5010 835 Companion Guide

The revision to the Medicare FFS Version 5010 835 Health Care Claim Payment/Advice Companion Guide Version 2.1 of the Medicare FFS Version 5010 835 Companion Guide has now been published to the following website: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html.

Source: Change Request 7373

NOTES

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