DME MAC Jurisdiction A Resource
INFORMATION FOR DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, & VT

December 2013
Number 30

Ordering and Referring Denial Edits Will Be Implemented on January 6, 2014 (CMS Message 201311-03)

CMS will instruct contractors to turn on Phase 2 denial edits on January 6, 2014. These edits will check the following claims for a valid individual National Provider Identifier (NPI) and deny the claim when this information is invalid:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A Home Health Agencies (HHAs).

For more information:

- **MLN Matters® Article #SE1305,**

  "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf

This bulletin should be shared with all healthcare practitioners and managerial members of the physician/supplier staff. Bulletins are available at no cost from our web site at:
http://www.medicarenhic.com/dme/

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2013-2014 Influenza (Flu) Resources for Health Care Professionals (SE1336) (GEN)

MLN Matters® Number: SE1336 Revised
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Note: *This article was revised on November 7, 2013, to add a reference to MLN Matters® Article MM8249 on page 2. All other information is unchanged.*

Provider Types Affected

This MLN Matters® Special Edition article is intended for all health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What You Need to Know

- Keep this Special Edition MLN Matters® article and refer to it throughout the 2013 - 2014 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know What to Do About the Flu!

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. MLN Influenza Related Products for Health Care Professionals

- *MLN Matters® Article MM8433: Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season* - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8433.pdf**

- *MLN Matters® Article MM8249: New Influenza Virus and Hepatitis B Virus Vaccine Codes* - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8249.pdf**

- *Quick Reference Information: Medicare Part B Immunization Billing chart* - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf**

- *Quick Reference Information: Preventive Services chart* - **http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf**

- *Preventive Immunizations booklet* - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Preventive-Immunizations-ICN907787.pdf**

- *MLN Preventive Services Educational Products Web Page* - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html**

- *Preventive Services Educational Products PDF* - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf**

2. Other CMS Resources

- **Seasonal Influenza Vaccines 2013 Pricing**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2013ASPFiles.html

- **Immunizations web page is located at**
  http://www.cms.gov/Medicare/Prevention/Immunizations/index.html

- **Prevention General Information is located at**
  http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html

- **CMS Frequently Asked Questions**
  http://questions.cms.gov/faq.php

- ***Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 - Immunizations**
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

- ***Medicare Claims Processing Manual* - Chapter 18, Preventive and Screening Services**
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

3. Other Resources

The following non-CMS resources are just a few of the many available where you may find useful information and tools for the 2013 - 2014 flu season:

- Advisory Committee on Immunization Practices - **http://www.cdc.gov/vaccines/acip/index.html**
- Flu Clinic Locator - **http://www.flucliniclocator.org**
- Other sites with helpful information include:
- Centers for Disease Control and Prevention - **http://www.cdc.gov/flu**;
  - Flu.gov - **http://www.flu.gov**;
  - Food and Drug Administration - **http://www.fda.gov**;
  - Immunization Action Coalition - **http://www.immunize.org**;
  - Indian Health Services - **http://www.ihs.gov/**;
  - National Alliance for Hispanic Health - **http://www.hispanichealth.org**;
  - National Foundation For Infectious Diseases - **http://www.nfid.org/influenza**;
  - National Library of Medicine and NIH Medline Plus - **http://www.nlm.nih.gov/medlineplus/immunization.html**;
  - National Network for Immunization Information - **http://www.immunizationinfo.org**;
  - National Vaccine Program - **http://www.hhs.gov/nvpo**;
  - Office of Disease Prevention and Health Promotion - **http://odphp.osophs.dhhs.gov**;
  - Partnership for Prevention - **http://www.prevent.org**; and
  - World Health Organization - **http://www.who.int/en**

Beneficiary Information

For information to share with your Medicare patients, please visit **http://www.medicare.gov** on the Internet.

Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries; however, Medicare may cover additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible.

Don't forget to immunize yourself and your staff. *Protect yourself from the flu.*

Remember - Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug. For more information on coverage and billing of the flu vaccine and its administration, please visit the CMS Medicare Learning Network® Preventive Services Educational Products (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html**)
and CMS Immunizations (**http://www.cms.gov/immunizations**) web pages.

While some health care professionals may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. HealthMap Vaccine Finder (**http://flushot.healthmap.org/**) is a free, online service where users can search for locations offering flu vaccines.

2014 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update (MM8474) (GEN)

MLN Matters® Number: MM8474
Related CR Release Date: October 25, 2013
Related CR Transmittal #: R2802CP

Related Change Request (CR) #: CR 8474
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

By the first week in December 2013:

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

What You Need to Do

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

Background

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

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

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

Additional Information

The official instruction, CR 8474 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2802CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

2014 Update to the Amount in Controversy (GEN)

The amount in controversy for ALJ hearing requests filed before December 31, 2013 is $140. This amount will remain at $140 for ALJ hearing requests filed on or after January 1, 2014.

The amount that must remain in controversy for review in Federal District Court requested before December 31, 2013 is $1,400. This amount will increase to $1,430 for appeals to Federal District Court filed on or after January 1, 2014.

Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131 (MM8404) (GEN)

MLN Matters® Number: MM8404
Related CR Release Date: September 6, 2013
Related CR Transmittal #: R2782CP

Related Change Request (CR) #: CR 8404
Effective Date: December 9, 2013
Implementation Date: December 9, 2013

Note: *This article was revised on October 22, 2013, to add a link to MM8403 (***http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8403.pdf***) that alerts HH providers that effective December 9, 2013, HHABN Form CMS-R-296 will be discontinued and HHCCN will replace the HHABN option boxes 2 and 3. HHABN option box 1 will be replaced by the ABN of Noncoverage (CMS-R-131). All information is unchanged*

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

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

Key Points from the Updated Chapter 30 Section 50

HHA Use of ABN - General Use

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

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

Table 1
Statutory Provisions Related to ABN Issuance for LOL purposes

Application of LOL for the Home Health Benefit Citation from the Act	Brief Description of Situation	Recommended Explanation for "Reason Medicare May Not Pay" section of ABN
Section 1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.

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

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

HHA Triggering Events

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

Table 2
Triggering Events for ABN issuance by HHAs*

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

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

- **HHA Initiations**
  The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:
  - The care is not medically reasonable and necessary;
  - The beneficiary is not confined to his/her home (is not considered homebound);
  - The beneficiary does not need skilled nursing care on an intermittent basis; or
  - The beneficiary is receiving custodial care only.

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

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

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

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

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

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

- **HHA Reductions**

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

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

- **HHA Terminations**

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

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

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

Effect of Other Insurers/Payers

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

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

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

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

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

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

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

HHA Exceptions to ABN Notification Requirements

ABN issuance is NOT required in the following HHA situations:

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

Other HHA ABN Guidance

1. ABN for Voluntary Notice by HHAs

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

2. Effect of Initial Payment Determinations on Liability

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

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

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

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

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

Outpatient Therapy Services Use of the ABN

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

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

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

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

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

THERAPY CAP HAS BEEN MET - ABN MANDATORY EXAMPLE: A beneficiary has recently been receiving Physical Therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. She requests continued PT services two times a week even though PT is no longer

medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

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

Additional Information

The official instruction, CR8404, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf** on the CMS website. The revised portions of the "*Medicare Claims Processing Manual*" are a part of CR8404. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Claim Status Category and Claim Status Codes Update (MM8446) (GEN)

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

Provider Types Affected

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

What You Need to Know

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

All code changes approved during the September 2013 committee meeting will be posted on or about November 1, 2013 at **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/**
and **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/** and are reflected in the X12 277 transactions issued on and after the date of implementation of this CR8446 (January 1, 2014).

Background

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

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

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

Additional Information

The official instruction, CR 8446 issued to your MAC regarding this change may be viewed at **http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2792CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Denial for Power Mobility Device (PMD) Claim from a Supplier of Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) When Ordered By a Non-Authorized Provider (MM8239) (MOB)

MLN Matters® Number: MM8239
Related CR Release Date: November 6, 2013
Related CR Transmittal #: R1305OTN

Related Change Request (CR) #: CR 8239
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

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

1. *Social Security Act* Section 1834(a)(1)(E)(iv) standards for power wheelchairs;
   - Effective on the date of the enactment of this subparagraph in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in Section 1861(r)(1)), a PA, NP or CNS (as those terms are defined in Section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

2. *Social Security Act* Section 1861(r)(1)
   - The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)).

3. *Social Security Act* Section 1861(aa)(5)
   - The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a PA or NP who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law),

and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

- The term "clinical nurse specialist" means, for purposes of this title, an individual who is a registered nurse and is licensed to practice nursing in the State in which the CNS services are performed; and holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

4. Based on 42 CFR Part 410.38(c), the following definitions apply: PMD means a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

Key Points of CR8239

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

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

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

Medicare PECOS

CODE	APPROVED PHYSICAN SPECIALTIES
01	GENERAL PRACTICE
02	GENERAL SURGERY
03	ALLERGY/IMMUNOLOGY
04	OTOLARYNGOLOGY
05	ANESTHESIOLOGY
06	CARDIOVASCULAR DISEASE (CARDIOLOGY)
07	DERMATOLOGY
08	FAMILY PRACTICE
09	INTERVENTIONAL PAIN MANAGEMENT
10	GASTROENTEROLOGY
11	INTERNAL MEDICINE
12	OSTEOPATHIC MANUPULATIVE MEDICINE
13	NEUROLOGY
14	NEUROSURGERY
16	OBSTETRICS/GYNECOLOGY
17	HOSPICE/PALLIATIVE CARE
18	OPHTHALMOLOGY
20	ORTHOPEDIC SURGERY
21	CARDIAC ELECTROPHYSIOLOGY
22	PATHOLOGY
23	SPORTS MEDICINE
24	PLASTIC AND RECONSTRUCTIVE SURGERY
25	PHYSICAL MEDICINE AND REHABILITATION
26	PSYCHIATRY
27	GERIATRIC PSYCHIATRY
28	COLORECTAL SURGERY (PROCTOLOGY)
29	PULMONARY DISEASE
30	DIAGNOSTIC RADIOLOGY
33	THORACIC SURGERY
34	UROLOGY
36	NUCLEAR MEDICINE

CODE	APPROVED PHYSICAN SPECIALTIES
37	PEDIATRIC MEDICINE
38	GERIATRIC MEDICINE
39	NEPHROLOGY
40	HAND SURGERY
44	INFECTIOUS DISEASE
46	ENDOCRINOLOGY
66	RHEUMATOLOGY
72	PAIN MANAGEMENT
76	PERIPHERAL VASCULAR DISEASE
77	VASCULAR SURGERY
78	CARDIAC SURGERY
79	ADDICTION MEDICINE
81	CRITICAL CARE (INTENSIVISTS)
82	HEMATOLOGY
83	HEMATOLOGY/ONCOLOGY
84	PREVENTATIVE MEDICINE
85	MAXILLOFACIAL SURGERY
86	NEUROPSYCHIATRY
90	MEDICAL ONCOLOGY
91	SURGICAL ONCOLOGY
92	RADIATION ONCOLOGY
93	EMERGENCY MEDICINE
94	INTERVENTIONAL RADIOLOGY
98	GYNECOLOGICAL ONCOLOGY
C0	SLEEP LABORATORY/MEDICINE

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

CODE	APPROVED NON-PHYSICIAN SPECIALTY
50	NURSE PRACTITIONER
89	CLINICAL NURSE SPECIALIST
97	PHYSICIAN ASSISTANT

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

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

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

Additional Information

The official instruction, CR 8239, issued to your DME/MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1305OTN.pdf** on the CMS website. If you have any questions, please contact your DME/MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website. For a look at face-to-face requirements and a checklist you may review SE1112, "*Power Mobility Device Face-to-Face Examination Checklist*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1112.pdf** on the CMS website.

Display of ICD-10 Local Coverage Determinations (LCDs) on the Medicare Coverage Database (MCD) (MM8348) (GEN)

MLN Matters® Number: MM8348
Related CR Release Date: September 6, 2013
Related CR Transmittal #: R1293OTN

Related Change Request (CR) #: CR8348
Effective Date: October 7, 2013
Implementation Date: April 10, 2014

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Additional Information

The official instruction, CR 8348 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1293OTN.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Enrollment Denials When Overpayment Exists (MM8039) (GEN)

MLN Matters® Number: MM8039 Revised
Related CR Release Date: August 1, 2013
Related CR Transmittal #: R479PI

Related Change Request (CR) #: CR 8039
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Note: *This article was revised on October 17, 2013, to reflect the revised CR8039 issued on August 1. Several examples and clarifying statements have been added. In addition, the transmittal number and the Web address for accessing CR8039 were revised.*

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers, including current owners of an enrolling provider or supplier or the enrolling physician or non-physician practitioner, submitting enrollment applications to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Carriers, Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs), and A/B MACs).

What You Need to Know

This article, based on Change Request (CR) 8039, informs you that Medicare contractors may deny a Form CMS-855 enrollment application if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing or delinquent overpayment that has not been repaid in full at the time an application for new enrollment or Change of Ownership (CHOW) is filed.

Background

Under 42 Code of Federal Regulations (CFR) Section 424.530(a)(6), an enrollment application may be denied if the current owner (as that term is defined in 42 CFR Section 424.502) of the applying provider or supplier, or the applying physician or non-physician practitioner has an existing or delinquent overpayment that has not been repaid in full at the time the application was filed.

(Under 42 CFR 424.502, the term "Owner" means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in Sections 1124 and 1124A(A) of the *Social Security Act*) of the applying provider or supplier)

Overpayments are Medicare payments that a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States Government.

Upon receipt of a CMS-855A, CMS-855B, or CMS-855S application, the Medicare contractor will determine -whether any of the owners listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment.

Upon receipt of a CMS-855I application, the Medicare contractor will determine whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term "non-physician practitioner" includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.)

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR 424.530(a)(6) as the basis.

Consider the following examples:

Example #1: Hospital X has a $200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the $50,000 overpayment was attached to him as the sole proprietor.

Example #3: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as an LLC of which he is only a 30 percent owner; the practice is named "JS Medicine, LLC." A denial is not warranted because the provision applies to "all" owners collectively and, again, the $50,000 overpayment was attached to him.

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

Note that CR8039 applies only to initial enrollments and new owners in a CHOW. Note also that if the Medicare contractor determines that the overpayment existed at the time the application was filed, but the debt was paid in full by the time the contractor performed its review, the contractor will not deny the application because of that overpayment.

Additional Information

The official instruction, CR8039, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R479PI.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856) (SE1305) (GEN)

MLN Matters® Number: SE1305 Revised **Related Change Request (CR) #: 6421, 6417, 6696, 6856**
Related CR Release Date: N/A **Effective Date: N/A**
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN **Implementation Date: N/A**

Note: *This article was revised on November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the Advance Beneficiary Notice, CARC codes and DME rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same.*

Note: *This article was previously revised on April 19, 2013, to add references to the CMS-1450 form and to add question h. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at* **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html** *on the CMS website.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,

- Part B providers and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and

- Part A Home Health Agency (HHA) services who submit claims to Regional Home Health Intermediaries (RHHIs), Fiscal Intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.

- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

Provider Action Needed

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

What Providers Need to Know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the *Affordable Care Act* requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. **When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html** on the CMS website. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

Background

The *Affordable Care Act*, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a

Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, 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 clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A Home Health Agencies (HHA).

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

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
- Physician Assistants,
- Clinical Nurse Specialists,
- Nurse Practitioners,
- Clinical Psychologists,
- Interns, Residents, and Fellows,
- Certified Nurse Midwives, and
- Clinical Social Workers.

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

CMS would like to highlight the following limitations:

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

Questions and Answers Relating to the Edits

1. What are the ordering and referring edits?

The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits were implemented in two phases:

Phase 1 - Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

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

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

For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

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

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

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

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

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

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. (*NPIs were added only when the matching criteria verified the NPI.*)

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

Phase 2: Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

254D or 001L	Referring/Ordering Provider Not Allowed To Refer/Order
255D or 002L	Referring/Ordering Provider Mismatch

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing **required matching NPI**.

Below are the denial edits for Part A HHA providers who submit claims:

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

Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you, the ordering/referring provider, need to ensure that:**

a. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
  - i. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - iii. 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).
  - iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

b. If you do not have an enrollment record in Medicare.

- You need to submit **either an electronic application through the use of internet-based PECOS or a paper enrollment application** to Medicare.
  - i. **For paper applications** - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - ii. **For electronic applications** - complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
  - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
  - iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (**http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html**).

c. You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.

When you enrolled in Medicare, you indicated your Medicare specialty. **Any** physician specialty (Chiropractors are excluded) and **only** the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.
- Ensure you are correctly spelling the Ordering/Referring Provider's name.
- If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits.
- The Ordering Referring Report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report.

f. Make sure your claims are properly completed.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the Ordering and Referring file found on **CMS.gov**.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the Ordering/Referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, Billing Providers should contact their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the *Affordable Care Act* requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

g. What if my claim is denied inappropriately?

If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

h. How will the technical vs. professional components of imaging services be affected by the edits?
Consistent with the *Affordable Care Act* and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

i. Are the Phase 2 edits based on date of service or date of claim receipt?
The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?
Claims for capped rental items will continue to be paid for up to 13 months from the implementation date of the Phase 2 edits to allow coverage for the duration of the capped rental period.

Additional Guidance

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

2. **Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

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

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

Note: You must obtain a National Provider Identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at **https://nppes.cms.hhs.gov/NPPES/Welcome.do** on the CMS website. For more information about NPI enumeration, visit **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html** on the CMS website.

Additional Article Updates

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

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

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

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

MLN Matters Article MM6856, "*Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare Regional Home Health Intermediaries (RHHIs)*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf** on the CMS website.

MLN Matters Article SE1311, "*Opting out of Medicare and/or Electing to Order and Refer Services*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf** informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

If you have questions, please contact your Medicare Carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Further Details on the Revalidation of Provider Enrollment Information (SE1126) (GEN)

MLN Matters® Number: SE1126 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on December 9, 2013, to include the 2014 application fee amount of $542.00. All other information remains the same.*

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's Contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries

(RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Impact to You

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

What You Need to Know

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

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

What You Need to Do

When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855;
- Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; and
- If applicable, pay your fee by going to **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do**.

Background

Section 6401 (a) of the *Affordable Care Act* established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. **Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted.** Excluded from the revalidation requirements are providers enrolled solely to order and refer items or services to Medicare beneficiaries and practitioners who have opted out of the Medicare program.

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

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

CMS asks all providers who receive a request for revalidation to respond to that request.

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

- **For providers in PECOS** - the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your MAC. Contact information may be found at

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

CMS will provide the MACs with a list of providers/suppliers requiring revalidation every 60 days beginning October 2013. Within 60 days of receiving the CMS list, MACs will mail the revalidation notices.

Large groups (200+ members) accepting reassigned benefits from providers identified on the CMS list will receive a letter from their MACs informing them that providers linked to their group have been selected to revalidate. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. The letter and spreadsheet will be mailed to the group's correspondence address within 15 days of the MAC receiving the CMS list. This is informational only. Groups should not take any action to revalidate their providers until asked by their MAC to do so.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize Internet-based PECOS or the CMS list available on CMS.gov to determine if their providers have been mailed a revalidation notice.

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

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

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

Section 6401(a) of the *Affordable Care Act* also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $532.00 for Calendar Year (CY) 2013. The fee for CY 2014 is $542.00. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

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

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

A 60-day extension is available if more time is needed to complete the revalidation process. Extension requests should be coordinated with your MAC and requested in writing (fax/email permissible) or via phone. The Individual provider, the Authorized or Delegated Official of the group or the enrollment contact person can request the extension.

A group may request an extension on behalf of individuals reassigned to their group. Group extensions shall also be coordinated through your MACs and must meet the following requirements.

a. Only permitted if the provider reassigns all benefits to the group requesting the extension,
b. The extension is requested by the Authorized or Delegated Official of the group or the enrollment contact person, and
c. The Providers' name, National Provider Identifier (NPI) and justification as to why an extension is needed is provided. The extension can be requested in writing (fax/email permissible) or via phone.

Additional Information

To find out whether a provider/supplier has been mailed a revalidation notice go to **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html** on the CMS website.

A sample revalidation letter is available at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf** on the CMS website. A revalidation checklist is available at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html** on the CMS website.

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

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

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

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

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

If you have questions, contact your MAC. 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.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - October 1, 2013 version 3.0.3 (MM8518) (GEN)

MLN Matters® Number: MM8518
Related CR Release Date: November 15, 2013
Related CR Transmittal #: R1316OTN

Related Change Request (CR) #: CR 8518
Effective Date: January 1, 2014
Implementation April 7, 2014

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8518, from which this article is taken, instructs Medicare contractors to report only the code combinations that are listed in the current version of the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of CARC and RARC Rule. The spreadsheet attached to CR8518 (which is available also at

http://www.caqh.org/CORECodeCombinations.php) shows the change log for CORE Code Combination version 3.0.3 updates published on October 1, 2013.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the *Affordable Care Act*. The *Health Insurance Portability and Accountability Act* (HIPAA) amended the Act by adding Part C - Administrative Simplification - to Title XI of the *Social Security Act*, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently, and to achieve greater uniformity in the transmission of health information.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing. Through the *Affordable Care Act*, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The *Affordable Care Act* defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE published Code Combination version 3.0.3 on October 1, 2013. This update is based on July, 2013 CARC and RARC updates as posted at the WPC website. You may review these updates at: **http://www.wpc-edi.com/reference** for CARC and RARC updates and **http://www.caqh.org/CORECodeCombinations.php** for CAQH CORE defined code combination updates.

Additional Information

The official instruction, CR 8518 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1316OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

In CR8365, released on August 16, 2013, CMS instructed Medicare contractors to implement this updated rule set by January 6, 2014. You can find the associated MLN Matters® Article, MM8365 "*Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8365.pdf** on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Improve Your Patients' Health with the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) (SE1338) (GEN)

MLN Matters® Number: SE1338 Re-issued
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Note: *This article was re-issued on November 27, 2013.*

Provider Types Affected

Health care professionals eligible to furnish the IPPE or AWV.

What You Need to Know

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

- The Initial Preventive Physical Examination (IPPE) (also known as the "Welcome to Medicare" Preventive Visit); and
- The Annual Wellness Visit (AWV).

These preventive benefits allow you to assess your patients' health on an annual basis to help you determine if they have any risk factors and if they are eligible for other preventive services and screenings that Medicare covers.

These preventive benefits are a great way for you to detect illnesses in their earliest stages when treatment works best. The average reimbursement level for the AWV is about $107 and about $150 for the IPPE with no patient deductible or co-pay.

Note: Please check the physician fee schedule for the exact amount of reimbursement for your locality and setting. You can view the physician fee schedule by visiting http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

The Initial Preventative Physical Exam IPPE ("Welcome to Medicare" Preventive Visit)

Medicare covers an IPPE for all patients who have newly enrolled in Medicare Part B.

- The patient must receive this service within the first 12 months after the effective date of their Medicare Part B coverage.
- The IPPE is a one-time benefit.
- The IPPE consists of the following: o Review the patient's medical and social history;
    - Review potential risk factors for depression and other mood disorders;
    - Review functional ability and level of safety;
    - Measurement of height, weight, body mass index (BMI), and visual acuity screening.
    - End-of-life planning (upon agreement of the individual);
    - Education, counseling and referral based on the review of previous 5 components; and
    - Education, counseling and referral for other preventive services, including a brief written plan such as a checklist.

For more information about the IPPE, please see "Quick Reference Information: The ABCs of the IPPE" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf on the CMS website.

The AWV or Annual Wellness Visit

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period; and
- Who have not gotten either an IPPE or AWV within the previous 12 months.

Medicare pays for only one first AWV. Medicare will pay for a subsequent AWV for each patient annually. **Note:** The elements in first and subsequent AWVs, and the codes to bill them, are different.

- The first AWV includes the following elements: o A health risk assessment;
    - Establishment of a current list of provider and suppliers;
    - Review of medical and family history;
    - Measurement of height, weight, BMI, and blood pressure;
    - Review of potential risk factors for depression and other mood disorders;
    - Review of functional ability and level of safety;
    - Detection of any cognitive impairment the patient may have;
    - Establishment of a written screening schedule (such as a checklist);
    - Establishment of a list of risk factors; and
    - Provision of personalized health advice and referral to appropriate health education or other preventive services.

- Subsequent AWVs include the following elements: o Review of updated health risk assessment;
    - Update medical and family history;
    - Update of list of current providers and suppliers;
    - Measurement of weight and blood pressure;
    - Detection of cognitive impairment the patient may have;
    - Update of the written screening schedule (such as a checklist);
    - Update of the list of risk factors; and
    - Provision of personalized health advice and referral to appropriate health education or other preventive services.

For more information about the AWV, please see:

- "*Quick Reference Information: The ABCs of the AWV*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf** or

- "*Providing the Annual Wellness Visit*" at: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AnnualWellnessVisit-ICN907786.pdf** on the CMS website.

Additional Information

The Medicare Learning Network® has published a variety of additional educational material on Medicare-covered Preventive Services, including:

- Preventive Services Educational Products: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/education_products_prevserv.pdf**;

- The Preventive Services MLN page: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html**; and

- MLN Matters® Articles Related to Medicare-Covered Preventive Benefits **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf**.

For general information about Medicare-covered preventive services, visit the CMS Prevention page at **http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html** on the CMS website. For information to share with your Medicare patients, please visit **http://www.medicare.gov** on the Internet.

International Classification of Diseases, 10th Revision (ICD-10) Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI) (MM8465) (GEN)

MLN Matters® Number: MM8465
Related CR Release Date: November 1, 2013
Related CR Transmittal #: R1303OTN

Related Change Request (CR) #: CR 8465
Effective Date: December 3, 2013
Implementation Date: March 3, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

For dates of service of October 1, 2014, and after, providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the DME Common Electronic Data Interchange (CEDI) during the designated testing week. Make sure that your billing staff is aware of these upcoming testing periods for ICD-10.

Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014.

CR8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week has been

created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week will give trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC's and the CEDI website as well as the CMS website.

The testing week will be March 3 through March 7, 2014.

Information About the Testing Week:

- Your MAC will announce and actively promote the testing week via listserv messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an email address for the trading partners to provide registration information. The registration site or email address information will be available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- On or before March 18, 2014, your contractor will report the following to CMS:
  - Number of trading partners conducting testing during the testing week.
  - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
  - Percent of test claims accepted versus rejected.
  - Report of any significant issues found during testing.

Additional Information

The official instruction, CR8465, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1303OTN.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Be sure to visit the "**What's New**" section of our Web site at
http://www.medicarenhic.com/dme/whatsnew.aspx
for the latest information and updates regarding the
Medicare program and DME MAC A

January 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8448) (DRU)

MLN Matters® Number: MM8448
Related CR Release Date: September 6, 2013
Related CR Transmittal #: R2780CP

Related Change Request (CR) #: CR 8448
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8448 which instructs Medicare contractors to download and implement the January 2014 Average Sales Price (ASP) drug pricing files; and, if released by the Centers for Medicare & Medicaid Services (CMS), the October 2013, July 2013, April 2013, and January 2013 drug pricing files for Medicare Part B drugs.

Medicare will use the January 2014 ASP and Not Other Classified (NOC) drug pricing files to:

- Determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2014, with dates of service January 1, 2014, through March 31, 2014; and
- Update the drug payment limits for claims for infusion drugs furnished through a covered item of DME processed or reprocessed on or after January 1, 2014, with dates of service on or after January 1, 2014.

You should make sure that your billing staffs are aware of these changes.

Background

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

The Average Sales Price (ASP) methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS); who will quarterly supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER). You can find this manual at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf** on the CMS website.

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

Files	Effective Dates of Service
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013

Please note that: 1) The ASP and NOC drug pricing files will contain the applicable payment allowance limits (i.e., 106% ASP, 106% Wholesale Acquisition Cost (WAC), or 95% Actual Wholesale Price (AWP)); and as a result, your Medicare contractor will not make any additional payment calculations; 2) For any drug or biological not listed in the ASP or NOC drug pricing files, your contractor will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17 (Drugs and Biologicals), Section 20.1.3 (Exceptions to Average Sales Price (ASP) Payment Methodology); which you can find at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf** on the CMS website; and 3) Your MAC will seek payment allowances from their local carrier for drugs and biologicals that are not on the ASP file.

In addition, you should be aware that your MAC will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information

The official instruction, CR 8448, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2780CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims (MM8401) (GEN)

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

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

Provider Types Affected

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

Provider Action Needed

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

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

- Claim Adjustment Reason Code (CARC) 16: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)"
- RARC MA50: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- Group Code-Contractual Obligation (CO).

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

Additional Information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Medicare Remit Easy Print (MREP) Annual Enhancement (MM8467) (GEN)

MLN Matters® Number: MM8467
Related CR Release Date: September 27, 2013
Related CR Transmittal #: R2795CP

Related Change Request (CR) #: CR 8467
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8467 which informs Medicare contractors about the following annual changes to the Medicare Remit Easy Print (MREP) software. Those changes are:

- Revise the MREP remittance advice layout to remove the blank line after each set of Claim Line details and
- Revise the MREP remittance advice layout by adding the Claim Adjustment Reason Code (CARC) Adjustment Amount (CARC-AMT) to the fields subtotaled for each claim.

Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the MREP software to help providers to transition from paper to electronic format of the remittance advice. The Electronic Remittance Advice (ERA) must be the standard format adopted under the *Health Insurance Accountability and Portability Act* (HIPAA). Currently the HIPAA adopted standard is the ASC X12 Transaction 835 version 005010A1. MREP users can view and print the ERA in humanly readable format and can send a hard copy remittance advice with their claims to payers after Medicare. Additionally, MREP users can run and download a number of special reports that have been added in response to enhancement requests from users. This software is available for free and has been updated on a yearly basis since its introduction in October 2005. CR8467 is instructing VIPs - the software developer - to update MREP based on requests received from users through the MACs and/or the CMS website.

Additional Information

The official instruction, CR 8467 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2795CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

MREP and PC Print Updates for Operating Rules Phase III 360 Rule Compliance (MM8479) (GEN)

MLN Matters® Number: MM8479
Related CR Release Date: November 6, 2013
Related CR Transmittal #: R1308OTN

Related Change Request (CR) #: CR 8479
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Provider Types Affected

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

What Provider Need to Know

This article is based on Change Request (CR) 8479 which informs Medicare standard system maintainers about changes to documentation requirements for electronic transactions.

Make sure that your billing staffs are aware of these changes.

Background

Section 1104 of the Patient Protection and *Affordable Care Act* (ACA) requires the Secretary to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purpose of financial and administrative transactions.

Key Points in CR 8479

- Medicare contractor's systems will publish text describing the Group Code/CARC/RARC/CAGC reject codes included in the remittance advice to trading partners using MREP, PC Print, or PCACE software to view/print all V5010 X12 835 transactions. All published text will contain corresponding code descriptions or definitions specified in the code lists without changing the meaning and intent of the descriptions.

- Medicare contractor's systems will publish text describing the corresponding CORE-defined Claim Adjustment/Denial Business Scenario on all V5010 X12 835 transactions for trading partners using MREP, PC Print, or PCACE software to view/print v5010 X12 835 transactions.

Additional Information

The official instruction, CR 8479 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1308OTN.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Payment Due to Sequestration (MM8378) (GEN)

MLN Matters® Number: MM8378 Revised
Related CR Release Date: July 25, 2013
Related CR Transmittal #: R2739CP

Related Change Request (CR) #: CR 8378
Effective Date: June 3, 2013
Implementation Date: January 6, 2014

Note: *This article was revised on September 5, 2013, to revise the title to be consistent with the Change Request. All other information is unchanged*

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

- 253 - Sequestration - Reduction in Federal Spending

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

Additional Information

The official instruction, CR 8378 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2014 (MM8434) (GEN)

MLN Matters® Number: MM8434
Related CR Release Date: September 20, 2013
Related CR Transmittal #: R2793CP

Related Change Request (CR) #: CR 8434
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

What You Need to Know

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

Background

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

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

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

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

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

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

Additional Information

The official instruction, CR8434 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2793CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Redaction of Health Insurance Claim Numbers (HICNs) in Medicare Redetermination Notices (MRNs) (MM8268) (GEN)

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

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

Provider Types Affected

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

What You Need to Know

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

Background

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

Additional Information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1296OTN.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice (MM8182) (GEN)

MLN Matters® Number: MM8182
Related CR Release Date: August 30, 2013
Related CR Transmittal #: R1291OTN

Related Change Request (CR) #: CR 8182
Effective Date: October 1, 2013
Implementation Date: October 7, 2013, except January 6, 2014 for claims processed by DME MACs

Note: *This article was revised on September 16, 2013, to add a reference to MM8365 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8365.pdf*) for business scenarios, descriptions and updates related to Rule 3 of the Operating Rule Set - CORE-defined Claim Adjustment and Denials to become effective January 1, 2014. All other information remains the same.*

Provider Types Affected

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

What You Need To Know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) by January 1, 2014.

Background

The *Health Insurance Portability and Accountability Act (HIPAA)* amended Title XI of the *Social Security Act* by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to Public Law 104-191, *Health Insurance Portability and Accountability Act of 1996*, which you can find at **http://aspe.hhs.gov/admnsimp/pl104191.htm#1173** on the internet.)

Through the *Affordable Care Act*, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to Electronic Data Interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at **http://www.ncvhs.hhs.gov/** on the internet.)

Note: *The same rules will also apply to Standard Paper Remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.*

The EFT & ERA Operating Rule Set includes the following rules:
(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule;
2. Phase III CORE 382 ERA Enrollment Data Rule;
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
4. CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT Operating Rules under the *Affordable Care Act* are mandating a standard use of those standard codes. The ERA/EFT Operating Rules mandate consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule), that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional Information Required - Missing/Invalid/Incomplete Documentation
This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional Information Required - Missing/Invalid/Incomplete Data from Submitted Claim
This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed Service Not Covered by Health Plan
This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for Billed Service Not Separately Payable
This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

Additional Information

The official instruction, CR8182, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1291OTN.pdf** on the CMS website You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) as an attachment to that CR. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2014 (MM8527) (GEN)

MLN Matters® Number: MM8527
Related CR Release Date: November 15, 2013
Related CR Transmittal #: R82GI

Related Change Request (CR) #: CR 8527
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, 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) 8527 which details the new Calendar Year (CY) 2014 Medicare premium, coinsurance, and deductible amounts. Make sure that your billing staffs are aware of these changes.

Background

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

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

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

The updated rates are as follows:

2014 PART A - HOSPITAL INSURANCE (HI) RATES

Deductible

- $1,216.00

Coinsurance

- $304.00 a day for 61st-90th day
- $608.00 a day for 91st-150th day (lifetime reserve days)
- $152.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)

Base Premium (BP)

- $426.00 a month

BP with 10% surcharge

- $468.60 a month

BP with 45% reduction
- $234.00 a month (for those who have 30-39 quarters of coverage)

BP with 45% reduction and 10% surcharge
- $257.40 a month

2014 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI) RATES

Standard Premium
- $104.90 a month

Deductible
- $147.00 a year

Pro Rata Data Amount
- $114.99 1st month
- $32.01 2nd month

Coinsurance
- 20 percent

Additional Information

The official instruction, CR 8527 issued to your MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R82GI.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Use of Claim Adjustment Reason Code 23 (MM8297) (GEN)

MLN Matters® Number: MM8297
Related CR Release Date: November 15, 2013
Related CR Transmittal #: R1318OTN

Related Change Request (CR) #: CR 8297
Effective Date: April 1, 2014
Implementation Date: April 7, 2014, except July 7, 2014, for suppliers billing DME MACs

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8279, from which this article is taken, modifies Medicare claims processing systems to use Medicare Claim Adjustment Reason Codes (CARC) 23 to report impact of prior payers' adjudication on Medicare payment in the case of a secondary claim.

Background

Effective April 1, 2013, CR8154 - "*Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update*" modified CARC 23 (The impact of prior payer(s) adjudication including payments and/or adjustments (Use only with Group Code OA)); to include the instruction that it must be used with Group Code OA (Other Adjustment). The Centers for Medicare & Medicaid Services (CMS) has become aware that the modification to this CARC has resulted in some issues for

Medicare. (You can find the MLN Matters article associated with CR8154 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8154.pdf** on the CMS website.)

CR8297, from which this article is taken, instructs the Medicare's Shared System Maintainers (SSMs) on how to use CARC 23 to report prior payers' adjudication in the case of a secondary claim.

Medicare beneficiaries may have multiple coverages that occur either before or after Medicare. If (per Coordination Of Benefits) Medicare is the secondary payer, the adjudication process has to take into consideration how previous payers have adjudicated the claim, and report accordingly on the Remittance Advice (RA). The implementation guide for the current Electronic Remittance Advice (ERA) - ASC X12 Transaction 835 version 5010 - has explicit instruction in the Front Matter, Section 1.10.2.13 (Secondary Payment Reporting Consideration) to:

> "Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments); and Claim Adjustment Group Code OA (Other Adjustment). Code OA is used to identify this as an administrative adjustment.…… It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." In these instances, reporting the actual payment would prevent the transaction from balancing.

Medicare does not have to report everything a previous payer has done, because that information is reported by that payer to the provider through the previous payer's Remittance Advice (RA). In order to generate and send a balanced Medicare RA and Coordination of Benefits (COB) Claim, Medicare should report only the part of previous payers' adjudication that impacts Medicare calculation of payment and adjustments.

Specifically, CR8279 requires the Medicare SSMs to report:

1. The Medicare allowed amount in the appropriate claim or service level "AMT" segment using qualifier AU (claim level) or B6 (service level) in AMT01 (Actual Amount Qualifier Code);

2. Any patient responsibility, remaining after coordination of benefits with the previous payer(s), with Group Code "PR" (Patient Responsibility) and the appropriate Claim Adjustment Reason Code (for example: 1 - Deductible Amount, 2 - Coinsurance Amount); and

3. Any further adjustment, taken by Medicare as a result of previous payer(s) payment and/or adjustment(s), with Group Code OA and Claim Adjustment Reason Code 23.

Additional Information

The official instruction, CR8279 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1318OTN.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

MLN Connects™ Provider e-News

MLN Connects™ Provider e-News for Thursday, September 12, 2013

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

MLN Connects™ National Provider Calls

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

MLN Education Products Update

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

Announcements and Reminders

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

Claims, Pricer, and Code Updates

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

MLN Connects™ Provider e-News for Thursday, September 19, 2013

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

MLN Connects™ National Provider Calls

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

MLN Education Products Update

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

Announcements and Reminders

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

Claims, Pricer, and Code Updates

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

MLN Connects™ Provider e-News for Thursday, September 26, 2013

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

Announcements

- Registration for MAC Satisfaction Indicator Closing September 30
- Influenza Season is Almost Here

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

MLN Educational Products Update

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

MLN Connects™ Provider e-News for Thursday, October 17, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-10-17-enews.pdf

MLN Connects™ National Provider Calls

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

Announcements

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

Claims, Pricers, and Codes

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

MLN Educational Products Update

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

MLN Connects™ Provider e-News for Thursday, October 24, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-10-24-enews.pdf

MLN Connects™ National Provider Calls

- Streamlined Access to PECOS, EHR, and NPPES - Registration Now Open
- Did You Miss This MLN Connects Call?

Announcements

- New Option for Laboratories to Meet CLIA Quality Control Requirements: Individualized Quality Control Plan
- Hospice Quality Reporting Program: Hospice Item Set Fact Sheet Now Available
- Open Payments: 2014 Teaching Hospital List Now Available

- Teaching Hospital Closures and Round 6 of Section 5506 of the *Affordable Care Act* - Applications due October 31
- Hospitals Must Attest by November 30 to Receive Payment for 2013 EHR Incentive Program Participation
- Are you Eligible to Participate in PQRS?

Claims, Pricers, and Codes

- FY 2012 Inpatient PPS PC Pricer Updated

MLN Educational Products Update

- MLN Products Available In Electronic Publication Format
- New MLN Educational Web Guides Fast Fact
- "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 1]" Educational Tool - Released
- "The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers" Fact Sheet - Reminder

MLN Connects™ Provider e-News for Thursday, October 31, 2013

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

MLN Connects™ National Provider Calls

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

Announcements

- National Breast Cancer Awareness Month
- Payment Rules Notice
- Proposed Quality Measures for EHR Incentive Program - Public Comments Due November 25
- MEDCAC - Request for Nomination of Members
- Therapy Services Functional Reporting FAQ Document Updated
- Program Year 2012 QRURs for Group Practices Are Here
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines
- EHR Incentive Programs: Important Payment Adjustment Information for Medicare EPs
- EHR Incentive Programs: Stage 1 Meaningful Use Calculator Includes Updated Measure Requirements
- Learn How Your Eligible Hospital's EHR Participation Affects Upcoming Payment Adjustments
- Create an ICD-10 Project Plan

Claims, Pricers, and Codes

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

MLN Educational Products Update

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

MLN Connects™ Provider e-News for Thursday, November 07, 2013

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

MLN Connects™ National Provider Calls

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

CMS Events

- Special Open Door Forum: Final Rule CMS-1599-F: Discussion of the Hospital Inpatient Admission Order and Certification; Two Midnight Benchmark for Inpatient Hospital Admissions.
- Special Open Door Forum: ACA Section 3004: Quality Reporting Program for Long Term Care Hospitals
- CMS Innovation Center Special Open Door Forum: Discussion of the Medicare Intravenous Immune Globulin (IVIG) Demonstration

Announcements

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

Claims, Pricers, and Codes

- FY 2014 Inpatient Prospective Payment System Pricer File Update 3

MLN Educational Products Update

- "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet - Released
- "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" Booklet - Revised
- "Resources for Medicare Beneficiaries" Fact Sheet-Revised
- "Global Surgery" Fact Sheet - Now Available in Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, November 14, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-14-eNews.pdf

MLN Connects™ National Provider Calls

- Streamlined Access to PECOS, EHR, and NPPES - Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 - Registration Now Open

MLN Connects™ Videos

- MLN Connects™ Videos on ICD-10

CMS Events

- Learn More About Open Payments Registration and Data Submission in Upcoming Webinar

Announcements

- Grandfathering Notices for DMEPOS Competitive Bidding Round 1 Recompete Due November 18
- Reassigning Benefits Using the Internet-based PECOS System

- Learn When EHR Payment Adjustment for Medicare Eligible Hospitals Begin
- Review Important Payment Adjustment Information for Medicare EPs
- Request a Review of 2012 PQRS Participation Results
- Identify How ICD-10 Will Affect Your Practice

Claims, Pricers, and Codes

- Pilot ICD-10 IOCE Code Lists Now Available for Public Comment
- ICD-10 MS-DRG Software and Reimbursement Mappings Now Available
- FY 2014 Inpatient Prospective Payment System Pricer File Update 3 - Revised

MLN Educational Products Update

- "Skilled Nursing Facility Prospective Payment System" Fact Sheet - Revised
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet - Reminder
- MLN Products Available In Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, November 21, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-21-eNews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Last Chance to Register
- CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule - Registration Now Open
- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 - Register Now
- Clarification from November 15 Call on the I&A System

CMS Events

- eHealth Summit

Announcements

- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
- Diabetes and Seasonal Influenza Vaccination
- Updated Incarcerated Beneficiary Claim Denial FAQs
- Learn More about PQRS and 2013 Program Participation with the New PQRS Fact Sheet
- ICD-10: Less Than One Year Out
- Hospitals Must Attest by November 30 to Receive Payment for 2013 EHR Incentive Program Participation

MLN Educational Products Update

- "Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services" MLN Matters® Article - Revised
- "The DMEPOS Competitive Bidding Program: Grandfathering Requirements for Non-Contract Suppliers" Fact Sheet-Revised
- "Hospital Reclassifications" Fact Sheet - Revised
- "Quick Reference Information: Medicare Immunization Billing" Educational Tool - Revised
- Updated MLN Matters® Search Indices
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists
- Submit Feedback on MLN Educational Products
- MLN Products Available In Electronic Publication Format

MLN Connects™ Provider e-News for Wednesday, November 27, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-27-eNews-PDF.pdf

MLN Connects™ National Provider Calls

- CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule - CE Credit Available
- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 - Register Now

CMS Events

- Provider Webinar on 2014 CMS eHealth Program Milestones for EPs

Announcements

- November is National Home Care and Hospice Month
- In Observance of World AIDS Day - Remember HIV Screenings
- Access Your 2012 eRx Incentive Program Feedback Report Today
- Learn How to Avoid the 2015 PQRS Payment Adjustment
- Hospitals: Attest by November 30 to Receive EHR Incentive Payment for 2013 Participation
- Learn More about Health Information Exchange in Stage 2 with New EHR tipsheet for Eligible Professionals
- Stay Informed: New and Updated FAQs for the EHR Incentive Programs
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines

MLN Educational Products Update

- "Vaccine Payments Under Medicare Part D" Fact Sheet - Released
- MLN Products Available in Electronic Publication Format
- New MLN Provider Compliance Fast Fact

MLN Connects™ Provider e-News for Thursday, December 05, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-05-Enews.pdf

MLN Connects™ National Provider Calls

- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 - Register Now
- Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius - Registration Now Open
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule - Registration Now Open
- Did You Miss This MLN Connects Call?

CMS Events

- Special Open Door Forum: Final Rule CMS-1599-F: Hospital Inpatient Admissions
- Hospice Item Set Training - Save the Date

Announcements

- National Influenza Vaccination Week - December 8-14
- Provider Enrollment Application Fee Amount
- Deadline for Physician-owned Hospitals to Report Ownership and Investment Information Extended to March 1
- CMS Announces Quality Strategy
- New Short-Term Acute Care PEPPER Released
- Reporting Period for EPs in the EHR Incentive Programs Ends December 31

MLN Educational Products Update

- "Improve Your Patients' Health with the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)" MLN Matters® Article - Released
- "Medical Privacy of Protected Health Information" Fact Sheet - Released

- "Vaccine Payments Under Medicare Part D" Fact Sheet - Released
- "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet - Revised
- "The DMEPOS Competitive Bidding Program: Traveling Beneficiary" Fact Sheet - Revised
- "The DMEPOS Competitive Bidding Program: Referral Agents" Fact Sheet - Revised
- "The DMEPOS Competitive Bidding Program: Enteral Nutrition" Fact Sheet - Revised
- "Communicating With Your Medicare Patients" Fact Sheet - Revised
- "DMEPOS Quality Standards" Booklet - Reminder
- "Medicare Coverage of Imaging Services" Fact Sheet - Reminder
- New MLN Educational Web Guides Fast Fact
- Submit Your Feedback on the MLN Learning Management System and Product Ordering System

CMS News Flash (GEN)

NEW and REVISED products from the Medicare Learning Network® (MLN)

- "*Annual Wellness Visit*," Podcast, ICN 908726, Downloadable only.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/2013-05-29-awv.html

- "*Medicare Enrollment and Claim Submission Guidelines*", Booklet, ICN 906764, Downloadable and hard copy.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf

- "*ICD-10-CM/PCS The Next Generation of Coding*," Fact Sheet, ICN 901044, Downloadable and Hard Copy.
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10Overview.pdf

- "*The ICD-10 Classification Enhancements*," Fact Sheet, ICN 903187, Hard Copy.
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10QuickRefer.pdf

- "*General Equivalence Mappings Frequently Asked Questions*," Booklet, ICN 901743, Downloadable only.
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf

- "*Medicare Enrollment Guidelines for Ordering/Referring Providers*," Fact Sheet, ICN 906223, downloadable.
  http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf

- "*Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information*," Fact Sheet, ICN 903766, Downloadable only.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf

Flu Season Isn't Over - Continue to Recommend Vaccination - While each flu season is different, flu activity typically peaks in February. Yet, even in February, the flu vaccine is still the best defense against the flu. The CDC (**http://www.cdc.gov/flu/index.htm**) recommends yearly flu vaccination for everyone 6 months of age and older; and although anyone can get the flu, adults 65 years and older are at greater risk for serious flu-related complications that can lead to hospitalization and death. Every office visit is an opportunity to check your patients' vaccination status and encourage flu vaccination when appropriate. And getting vaccinated is just as important for health care personnel who can get sick with the flu and spread it to family, colleagues and patients. Be an example by getting your flu vaccine and know that you're helping to reduce the spread of flu in your community. Note: influenza vaccines and their administration fees are covered Part B benefits. Influenza vaccines are NOT Part D-covered drugs. For More Information:

- 2012-2013 Seasonal Influenza Vaccines Pricing (**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html**)

- MLN Matters® Article MM8047, "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season." (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf**)

- CMS Medicare Learning Network® 2012-2013 Seasonal Influenza Virus Educational Products and Resources (**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Flu_Products.pdf**) and CMS Immunizations (**http://www.cms.gov/immunizations**) web pages for information on coverage and billing.

- HealthMap Vaccine Finder (**http://vaccine.healthmap.org/**) - a free, online service where users can find nearby locations offering flu vaccines as well as other vaccines for adults.

- The CDC's website (**http://www.cdc.gov/flu/freeresources/**) offers a variety of provider resources for the 2012-2013 flu season.

Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. **Note:** The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8433.pdf**), "*Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season*"

- MLN Matters® Article #SE1336 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1336.pdf**), "*2013-2014 Influenza (Flu) Resources for Health Care Professionals*"

- HealthMap Vaccine Finder (**http://vaccine.healthmap.org/**) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for Free Resources (**http://www.cdc.gov/flu/freeresources/**), including prescription-style tear-pads (**http://wwwn.cdc.gov/pubs/ncird.aspx#Flu**) that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project MLN Connects™ Video - Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on the CMS YouTube Channel (**http://www.youtube.com/watch?v=WLGofe1nPAo&feature=youtu.be**), Pat Brooks and Dr. Daniel Duvall from the Hospital and Ambulatory Policy Group of the Center for Medicare discuss the transition to ICD-10 for medical diagnosis and inpatient procedure coding:

- Hints for a smooth transition to ICD-10 in physician offices
- ICD-10 Implementation and preparation strategies
- Partial freeze prior to ICD-10 implementation
- Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project at CMS

In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the "*mailing list for referral agents*"

(**https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814**) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

The "**September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions**" (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/September-2013-ICD-10-CM-PCS-Billing-Payment-FAQs-Fact-Sheet-ICN908974.pdf**) Fact Sheet (ICN 908974) was released and is now available in downloadable format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date and billing and payment Frequently Asked Questions.

Several fact sheets that provide education to specific provider types on how to enroll in the Medicare Program and maintain their enrollment information using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) have been recently updated and are available in downloadable format from the Medicare Learning Network® (MLN). Please visit **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf** for a complete list of all MLN products related to Medicare provider-supplier enrollment.

Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MLNProducts_listserv.pdf** and start receiving updates immediately!

Fee Schedule Updates (GEN)

The 2013 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.aspx**. This quarter the following notices have been posted:

- There are no updates to the 4th Quarter 2012 Jurisdiction A DME MAC Fee Schedule
- 4th Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2013 Oral Anticancer Drug Fees

Note: The January 1 fees for the current calendar year are posted as the "Jurisdiction A DME MAC Fee Schedule" for that particular year, and these files are not changed throughout the year. Rather, separate notices are posted as fee revisions/updates become available. Please be sure you are viewing the appropriate file/notice for the item and date of service.

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

The LCDs can be found on the DME MAC A Web site at:
http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

LCDs can also be found on the CMS Web site
within the Medicare Coverage Database (MCD), which is accessible by going to:
http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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Billing Reminder: Nebulizers - Pharmacy Dispensing Fees for Inhalation Drugs (SPE)

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

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

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

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

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

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

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

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

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

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

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

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

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

Correct Coding - Supplies used with E0446 - Joint DME MAC Publication (OXY)

E0446 (TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES) as described in the narrative is all-inclusive. There is no separate reimbursement for any supplies used with this item. This includes items such as tape, dressings, tubing, etc.

If the supplies are billed separately, HCPCS code A9900 (MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE) must be used.

Claims for supplies used with E0446 will be denied as unbundling.

Claims for E0446 and related items will be denied as not reasonable and necessary. (National Coverage Determinations 20.29.C & 270.5)

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 web site: **https://www.dmepdac.com/**

Correct Coding Reminder - Monitoring Technology Used with Positive Airway Pressure Devices (PAP) and Respiratory Assist Devices (RAD) (SPE)

Many manufacturers of medical devices are now incorporating technology for monitoring and/or downloading various types of patient data. This information is then made available for review by the healthcare provider, DME supplier or in some cases, the beneficiary. This technology may be incorporated into the device itself or added as a separate module. Such technologies include, but are not limited to:

- Smart cards and readers
- USB/Thumb drive accessories
- Wired telephonic transmission modules
- Wireless modems

For example, Positive Airway Pressure Devices and Respiratory Assist Devices include technology to monitor compliance. This article serves as a reminder for the correct coding of these features.

Suppliers who elect to bill separately for monitoring technology must use HCPCS code A9279 (MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED). Code A9279 is to be used whether the monitoring technology is incorporated as part of the base item, supplied as an add-on module or is a stand-alone item. Claims for A9279 are denied as statutorily noncovered.

A9279 is all-inclusive. Use of multiple instances of A9279 to bill separately for individual features is incorrect coding.

Claims billed for monitoring technologies using other NOC codes such as E1399 [DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS] will be denied as incorrect coding.

Refer to the applicable Local Coverage Determination and related Policy Article for additional information on the coverage and coding of PAP and RAD items.

September 2013 CERT Enteral Dear Physician Letter

Dear Physician:

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

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

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

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

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

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

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

Sincerely,

Paul J. Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A
NHIC, Corp.

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C
CGS Administrators, LLC

Stacey V. Brennan, M.D., FAAFP
Medical Director, DME MAC, Jurisdiction B
National Government Services

Eileen M. Moynihan, MD, FACP, FACR
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions

TMP-EDO-0058 Ver. 4 09/18/2012

Frequently Asked Questions: Oxygen Use in Beneficiaries with Obstructive Sleep Apnea (OXY)

Medicare does not provide reimbursement for home oxygen as a treatment of Obstructive Sleep Apnea (OSA). However many beneficiaries with OSA have co-existing chronic pulmonary conditions that would justify coverage of home oxygen, after appropriate titration polysomnogram (PSG) and meeting the requirements specified in the Oxygen LCD. Both the Oxygen LCD and the Positive Airway Pressure Devices (PAP) LCD contain detailed information about the testing necessary to justify payment of home oxygen. This FAQ discusses some of the common scenarios seen. Refer to the LCDs for detailed information about coverage of PAP and home oxygen.

Following the Q&A, an algorithm is included to assist in analyzing OSA / home oxygen testing scenarios. Note that the algorithm does not itemize all coverage requirements for OSA or home oxygen. It is intended as an overview of qualification testing. Refer to the LCDs for detailed information about payment rules.

1. A beneficiary has a diagnosis of obstructive sleep apnea (OSA) and does not meet any of the Oxygen LCD Group I or Group II criteria, yet their physician has prescribed home oxygen therapy. In this instance, would the home oxygen be covered?

   Response: No, home oxygen would not be covered. In order for home oxygen to be reimbursed the payment rules described in the oxygen policy must be met.

2. A beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration polysomnogram (PSG) as described in the oxygen LCD. Following diagnosis and optimal treatment of the OSA during the titration PSG, it is discovered that the beneficiary is not using the PAP device as prescribed (refused the device, is non-compliant, etc.) but the physician has prescribed oxygen for use during sleep. In this instance, would the home oxygen be covered?

   Response: Yes, home oxygen is covered. For beneficiaries with OSA, the titration PSG is used to:

   a. Assure that the OSA is optimally treated thus satisfying the Oxygen LCD "chronic stable state" requirement, and
   b. Determine that the remaining hypoxia meets the Oxygen LCD qualification threshold.

   Beneficiary compliance with treatment after testing is not a factor in determining eligibility for payment of home oxygen.

   Note: This answer assumes that OSA is the only other concurrent condition that could affect blood oxygen levels and that the underlying lung disease is adequately treated and stable as required by the Oxygen LCD.

3. A beneficiary has a diagnosis of OSA and demonstrated oxygen desaturation during a titration polysomnogram (PSG) as described in the oxygen LCD; however, the beneficiary is unable to tolerate PAP therapy during the titration PSG. The physician does not prescribe PAP but rather prescribes oxygen therapy. In this instance, would the home oxygen be covered?

   Response: No, home oxygen is not covered. Oxygen is not the primary treatment for OSA. The Oxygen LCD requires that the beneficiary is optimally treated with respect to their OSA thus satisfying the Oxygen LCD "chronic stable state" requirement.

4. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary has tried PAP, other treatment options, such as an oral appliance, weight loss and surgery. All treatments have been determined by their physician to be unsuccessful. With no active OSA treatment, the beneficiary continues to desaturate at night ($\leq$ 88% for 5 total minutes or more), as evidenced by overnight oximetry testing. The physician has prescribed home oxygen for use at night. In this instance, would the home oxygen be covered?

   Response: This question actually has insufficient information to determine whether home oxygen might be eligible for payment. What is missing is information about the type of testing done. A titration PSG must have been performed. During the titration phase, optimal treatment with the PAP device must have been achieved. Only after optimal treatment with a PAP device can an assessment of the remaining hypoxia (if any) be done. For the beneficiaries remaining hypoxic while receiving optimal PAP therapy, home oxygen may be covered if the oxygen testing reaches the levels required by the oxygen LCD. Compliance with treatment for OSA is not a determining factor for qualification of home oxygen.

5. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). During a titration PSG that lasted more than 2 hours, the beneficiary was titrated with PAP to an AHI/RDI of <10 events per hour, yet continued to desaturate below 88% for more than five total minutes. The physician has prescribed oxygen for use in conjunction with the PAP. In this instance, would the home oxygen be covered?

   Response: Yes, home oxygen would be covered. The question restates the titration PSG requirements described in the LCDs. A titration PSG meeting these requirements can be used for qualification of home oxygen.

6. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary was prescribed a PAP and the physician has ordered a home overnight oximetry test that was performed on room air without the beneficiary using their PAP device. The beneficiary desaturated below 88% for more than five total minutes. In this instance, would the home oxygen be covered?

   Response: No, home oxygen would not be covered. Beneficiaries with diagnosed but untreated OSA are not in a "chronic, stable state". Therefore, they do not meet the Oxygen LCD Group I or Group II criteria. Only testing with a titration PSG may be used to qualify a beneficiary with OSA for concurrent payment of home oxygen.

7. A beneficiary has a diagnosis of OSA and has been diagnosed with a chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary was prescribed a PAP and the physician has ordered a home overnight oximetry test that was performed on room air with the beneficiary using their PAP device. The beneficiary desaturated below 88% for more than five total minutes. In this instance, would the home oxygen be covered?

   Response: No, home oxygen would not be covered. Only testing with a titration PSG may be used to qualify a beneficiary with OSA for concurrent payment of home oxygen.

8. A beneficiary has diagnoses of OSA and chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary has an oximetry testing performed during the day, while at rest. The beneficiary's resting SpO2 is < 88% and the beneficiary's physician has prescribed home oxygen therapy. In this instance, would home oxygen be covered?

   Response: Yes, home oxygen would be covered. This beneficiary meets the Oxygen LCD Group I criteria. Oximetry testing while the beneficiary is awake may be used for qualification of home oxygen. While awake OSA does not affect blood oxygen levels.

9. A beneficiary has diagnoses of OSA and chronic, severe lung disease (i.e., COPD, emphysema). The beneficiary has pulse oximetry testing performed during the day, while exercising. The beneficiary's baseline SpO2 is 92% and their SpO2 < 88% during exercise. The beneficiary is tested during exercise while on oxygen and their SpO2 is 92%. The physician prescribes home oxygen therapy for use during activity/exercise. In this instance, would home oxygen be covered?

   Response: Yes, home oxygen would be covered. This beneficiary meets the Oxygen LCD Group I criteria. As discussed in Q7, oximetry testing while awake continues to be acceptable for the qualification of home oxygen. OSA does not affect the blood oxygen levels of an awake beneficiary.

10. When oxygen qualification testing is obtained from a titration polysomnogram, is portable oxygen covered?

    Response: No, as with overnight oximetry, only stationary oxygen is justified based on titration polysomnography.

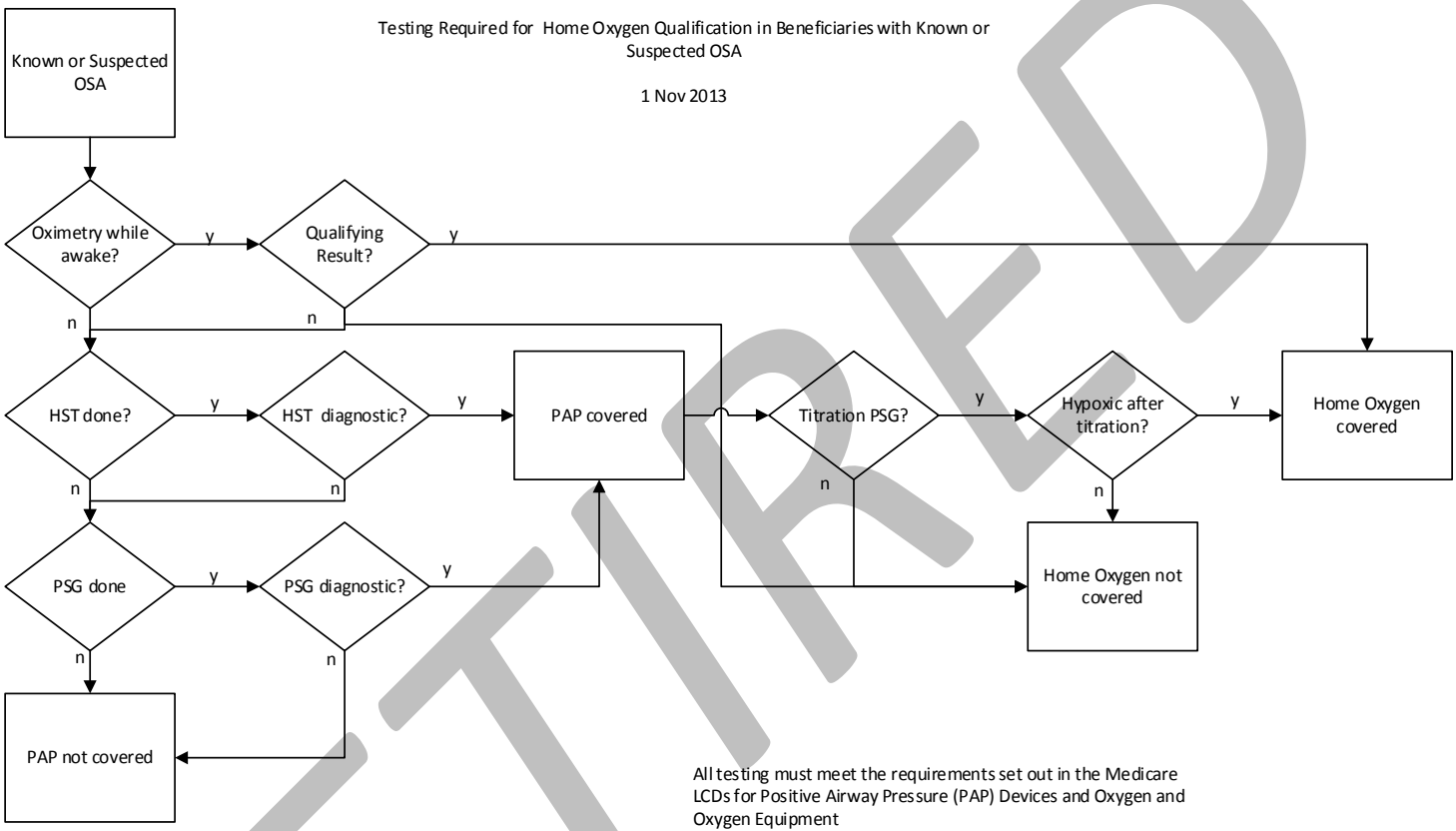
11. For a beneficiary now eligible for Medicare who is already on PAP and O2, are both therapies eligible for reimbursement?

    Response: Each therapy has separate and independent coverage criteria that must be met in order to be eligible for Medicare reimbursement. Items reimbursed by other payers prior to Medicare eligibility are not a determinant for Medicare program payment. Claims submitted to Medicare for items previously paid outside of Medicare are considered new, initial Medicare claims. All applicable coverage and documentation requirements in effect at the initial Medicare DOS must be met. There are two limited exceptions:
    - For PAP:
        a. The original testing done to diagnose OSA may be used to qualify for Medicare coverage if the results meet or exceed Medicare AHI/RDI requirements; and,

b. The 90-day compliance period is replaced with an in-person physician visit that documents (1) compliant use of the equipment and (2) benefit from therapy.

- For Home Oxygen:
  c. For beneficiaries who start oxygen while enrolled in a Medicare managed care plan, the blood oxygen testing used by the plan for qualification may be used for qualification purposes by fee-for-service Medicare.

Refer to the relevant LCD and related Policy Article for details about coverage and documentation requirements.



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

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have identified a growing trend in Comprehensive Error Rate Testing (CERT) errors for Enteral Nutrition related items. Suppliers are reminded of §1833(e) of the *Social Security Act* which precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records may include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be made available upon request from any auditing Medicare contractor.

Detailed Written Orders:

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

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

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

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

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

Clinical Records Documentation:

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions. Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

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

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

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

Nutrients

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

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

Continued Medical Need

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

- A recent order by the treating physician for refills
- A recent change in prescription

- A properly completed CMN or DIF with an appropriate length of need specified

Signature Requirements

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

Durable Medical Equipment Information Form (DIF)

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

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

Policy Article Revision Summary for November 27, 2013 (SPE)

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

Glucose Monitor

Policy Article

Revision Effective Date: 01/01/2014
CODING GUIDELINES:
Revised: Billing of testing supplies dispensed with initial issue of glucose monitor
Revised: Bundling table

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

LCD and Policy Article Revision Summary for November 15, 2013 (SPE)

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

Nebulizers

LCD

Revision Effective Date: 08/02/2011 (November 2013 Publication)
HCPCS CODES AND MODIFIERS:

Added: HCPCS code A7018

Policy Article

Revision Effective Date: 04/01/2013 (November 2013 Publication)
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
Revised: Refill Information

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.*

LCD and Policy Article Revision Summary for October 31, 2013 (SPE)

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

Urological Supplies

LCD

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

Policy Article

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

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

Power Mobility Devices Local Coverage Determination - Update (MOB)

The Power Mobility Devices Local Coverage Determination (LCD) has been revised to restore the original prescription requirements.

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

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

Reminder - National Mail Order Suppliers and Testing Supplies (SPE)

Suppliers selected for national mail order of diabetic testing supplies are reminded of the following regulations governing the provision of testing supplies:

- Contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. **The contract supplier is prohibited from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies.** The contract supplier may not furnish information about alternative brands to the beneficiary unless the beneficiary requests such information. [Emphasis added - See 42 CFR 414.422(e)(3)]

- Physicians have the option of prescribing a specific brand of glucose monitor if the physician determines that the particular brand or mode of delivery would avoid an adverse medical outcome for the beneficiary. If the physician prescribes a specific brand of monitor, the supplier has three (3) options:
    1) Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner; or,
    2) Consult with the physician or treating practitioner to find an appropriate alternative brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or
    3) Assist the beneficiary in locating a contract supplier that can furnish the particular brand.

  (See 42 CFR 414.420)

CMS and the DME MACs are monitoring utilization data and will refer to the appropriate contractor(s) for further investigation any National Mail Order supplier who is suspected of violating these and other terms of their contract.

Glucose monitors are covered under the Durable Medical Equipment benefit; therefore, the 5-year reasonable useful lifetime (RUL) rules apply. Additional information on RUL and replacement of DME may be found in the *Medicare Benefit Policy Manual* (Internet-only Manual, Publ. 100-2), Chapter 15, §110.2. Routine replacement or replacement due to a change in suppliers is non-covered by Medicare.

Results of Documentation Compliance Review (DCR) of Claims for HCPCS A4253 (SPE)

Documentation Compliance Reviews (DCRs) are nonclinical, technical reviews that evaluate the presence or absence of particular pieces of required documentation necessary for payment according to the Local Coverage Determination (LCD) for that DMEPOS item.

DME MAC A Medical Review has been performing a service-specific Documentation Compliance Review (DCR) of HCPCS Codes A4253 (Blood glucose test strips) claims. This type of review is conducted when data analysis indicates there is a pattern of insufficient documentation in a product category.

This review was initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

Documentation Requested

The following documentation is requested to perform the DCR:

- Detailed written order for the Glucose testing supplies, for the billed dates of service
- Valid Proof of Delivery
- A valid proof of request for refill of glucose testing supplies

Current Review Results

These findings are for claims reviewed from July 01, 2013 through September 30, 2013:

- The review involved DCRs of 10,289 claims (including reopenings)
- Of the 10,289 claims reviewed, 4,501 claims were denied resulting in a claim denial rate of 44%.
- An additional 4,298 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Primary Reasons for Denial

Based on review of the documentation received, following are common reasons for denial:

- Request for refill incomplete due to missing quantity remaining
- Proof of delivery missing or incomplete
- Detailed written order incomplete (ex. missing signature)

Next Step

Based on the results of this DCR, DME MAC A will continue to perform DCRs on HCPCS A4253. Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor.

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for HCPCS A4253. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to visit our web site at **http://www.medicarenhic.com** for all your educational needs and to review the following references:

- Items Provided on a Recurring Basis and Request for Refill Requirements - Revised - August 2012
  http://www.medicarenhic.com/viewdoc.aspx?id=467

- Coverage Reminder - Requirements for High Utilization of Glucose Monitor Strips and Lancets
  http://www.medicarenhic.com/viewdoc.aspx?id=1586

- Glucose Monitor LCD (L11530) and Related Policy Article (A33614)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- *The DME MAC Jurisdiction A Supplier Manual* **http://www.medicarenhic.com/dme/supmandownload.aspx**
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.

- DME MAC A Glucose Monitor Tutorial
  http://www.medicarenhic.com/dme/eduonline.aspx#tutorials

- DME MAC A Glucose Documentation Podcast
  http://www.medicarenhic.com/dme/eduonline.aspx#podcast

- Results of Documentation Compliance Review (DCR) of Claims for HCPCS A4253
  http://www.medicarenhic.com/viewdoc.aspx?id=2356

- Documentation Reminder - Glucose Monitor Logs for High-Utilization Claims
  http://www.medicarenhic.com/viewdoc.aspx?id=2319

- Glucose Monitors and Supplies - Dear Physician Letter
  http://www.medicarenhic.com/dme/phyletters.aspx

Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390 (OXY)

Documentation Compliance Reviews (DCRs) are nonclinical, technical reviews that evaluate the presence or absence of particular pieces of required documentation necessary for payment according to the Local Coverage Determination (LCD) for that DMEPOS item.

DME MAC A Medical Review has been performing a service-specific Documentation Compliance Review (DCR) of HCPCS Code E1390 (Oxygen Concentrator) claims. This type of review is conducted when data analysis indicates there is a pattern of insufficient documentation in a product category. This review was initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

Documentation Requested

The following documentation is requested to perform the DCR:

- A copy of the most recent Certificate of Medical Necessity (CMN) prior to the date of service
- The treating physician's detailed written order for the DMEPOS item(s) (CMN can serve as detailed written order if sufficiently completed)
- If the Date of Service (DOS) is prior to the signature date on the Detailed Written Order (DWO), proof of a dispensing order must be submitted
- Copy of the beneficiary's most recent arterial blood gas PO2 and/or oxygen saturation test value reported on the CMN
- Documentation of a physician office visit prior to the initial date of service (The physician's office visit needs to be within 30 days prior to the initial CMN Date.)
- Valid Proof of delivery

Current Review Results

These findings are for claims reviewed from July 01, 2013 through September 30, 2013:

- The review involved DCRs of 4,521 claims (including reopenings)
- Of the 4,521 claims reviewed, 1,904 claims were denied resulting in a claim denial rate of 42%
- An additional 318 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR)

Primary Reasons for Denial

Based on review of the documentation received, the following are the common reasons for denial, consistent with previous findings:

- No documentation of the treating physician visit 30 days prior to the Initial CMN was submitted
- No documentation of the beneficiary's most recent blood gas study/oxygen saturation test was submitted
- Proof of delivery was not submitted or was incomplete

Next Step

Based on the results of this DCR, DME MAC A will continue to perform DCRs on HCPCS E1390. Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor.

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for HCPCS E1390. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to visit our web site at **http://www.medicarenhic.com** for all your educational needs and to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768) **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- *The DME MAC Jurisdiction A Supplier Manual* **http://www.medicarenhic.com/dme/supmandownload.aspx**
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.

- CERT Physician Letter - Oxygen & Supplies
  http://www.medicarenhic.com/dme/phyletters.aspx

- Frequently Asked Questions (search word oxygen)
  http://www.medicarenhic.com/faqs.aspx?categories=DME

- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: May 17, 2013; February 08, 2013; October 12, 2012; June 29, 2012; March 2, 2012; November 04, 2011; August 26, 2011; November 05, 2010; and June 09, 2010
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

Quiz yourself and your staff.
Visit the DME MAC A Test Your Knowledge Quizzes today at:
http://www.medicarenhic.com/dme/dmequizindex.aspx

Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (O&P)

Historical Review Results

A widespread complex medical review was performed for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This review resulted in a Charge Denial Rate (CDR) of 62%. A summary of findings was published on the NHIC website on June 14, 2013. Based on this result, a widespread prepayment review was continued.

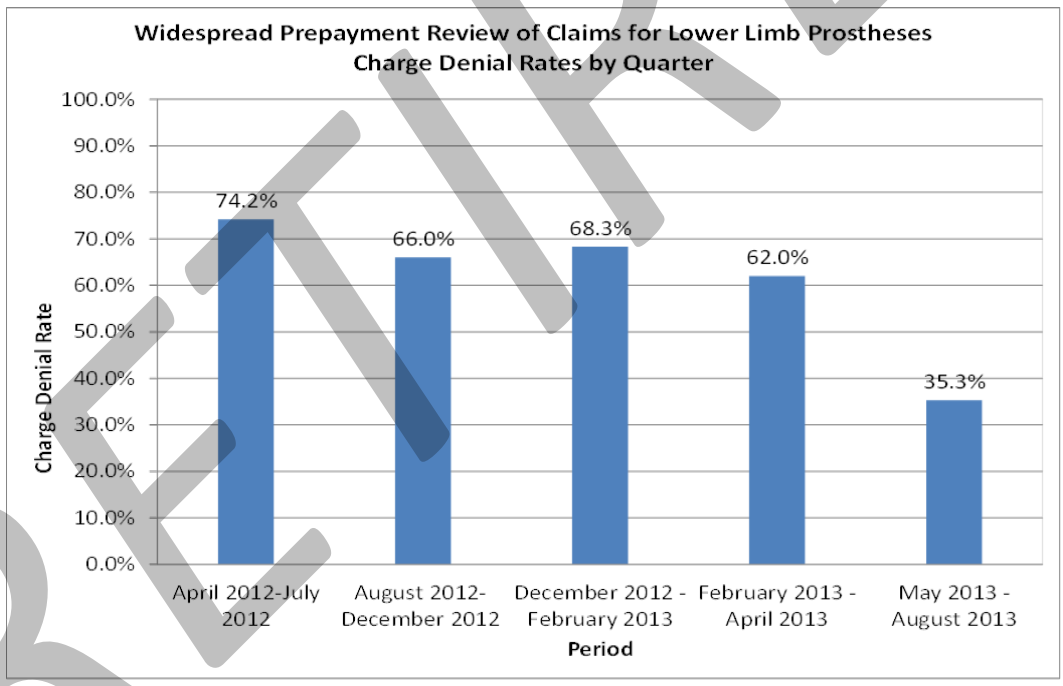
Current Review Results

The DME MAC Jurisdiction A has completed a widespread prepayment complex review of claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided.

The review involved prepayment complex medical review of 179 claims submitted by 109 suppliers for claims processed May 2013 to August 2013. Responses to the Additional Documentation Request (ADR) were not received for 28 (15%) of the claims. For the remaining 151 claims, 81 claims were allowed and 70 were denied resulting in a claim denial rate of 46%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 35.3%.

Charge Denial Rate Historical Data

The following chart depicts the Charge Denial Rate from previous quarters to current:



Reasons for Denial

Based on review of the documentation received, the following are the reasons for denial: Note that the percentages noted below reflect the fact that a claim could have more than one missing/incomplete item.

Lack of Medical Record Documentation

- 14.5% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 11% of the denied claims were missing the evaluation/assessment documentation for the functional level of item(s) billed (prosthetist assessment).

Clinical documentation did not support the functional level of the Lower Limb Prosthesis

- 21% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 3% of the denied claims were missing the proof of delivery. Delivery is missing items delivered; must be documented with a narrative description or a manufacturer name and model number.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Lower Limb Prostheses claims.

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed.
Missing: Clinician documentation to support functional level of device and to corroborate the prosthetist's records and the evaluation/assessment documentation for the functional level of item(s) billed.

Example 2:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the evaluation/assessment documentation for the functional level of item(s) billed, which details the functional level of the items billed.
Missing: Clinical documentation to support functional level of the device and to corroborate the prosthetist's records. Also missing was proof of delivery, which validates that the beneficiary received the items that were billed.

Example 3:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items dispensed, treating physician's signature and date, and the start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed; and the prosthetist's evaluation/assessment documentation detailing the functional levels of items billed.
Missing: The submitted clinical documentation did not support the functional level of the device and did not corroborate the prosthetist's records. Since the prosthetist is a supplier, the prosthetist's records must be corroborated by the information in the medical record.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided.

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews. One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs). When a supplier achieves and maintains high quality accuracy and ADR response rate over three (3) quarterly periods, the supplier will be temporarily removed from that particular widespread review. The supplier's authorized official will be notified and provided details of this decision.

Questions and comments can be sent to the DME MAC Jurisdiction A Provider Compliance mailbox at:
dme_mac_jurisdiction_a_provider_compliance@hp.com

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for Lower Limb Prostheses claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- *The DME MAC Jurisdiction A Supplier Manual* (Chapter 10: Includes Standard Documentation Requirements)
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/phyletters.aspx
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/phyletters.aspx
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (08/24/2012, 12/28/2012, 03/06/2013, 06/14/2013)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Results of Widespread Prepayment Probe for Lower Limb Prostheses (11/30/2011)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (PEN)

Historical Review Results

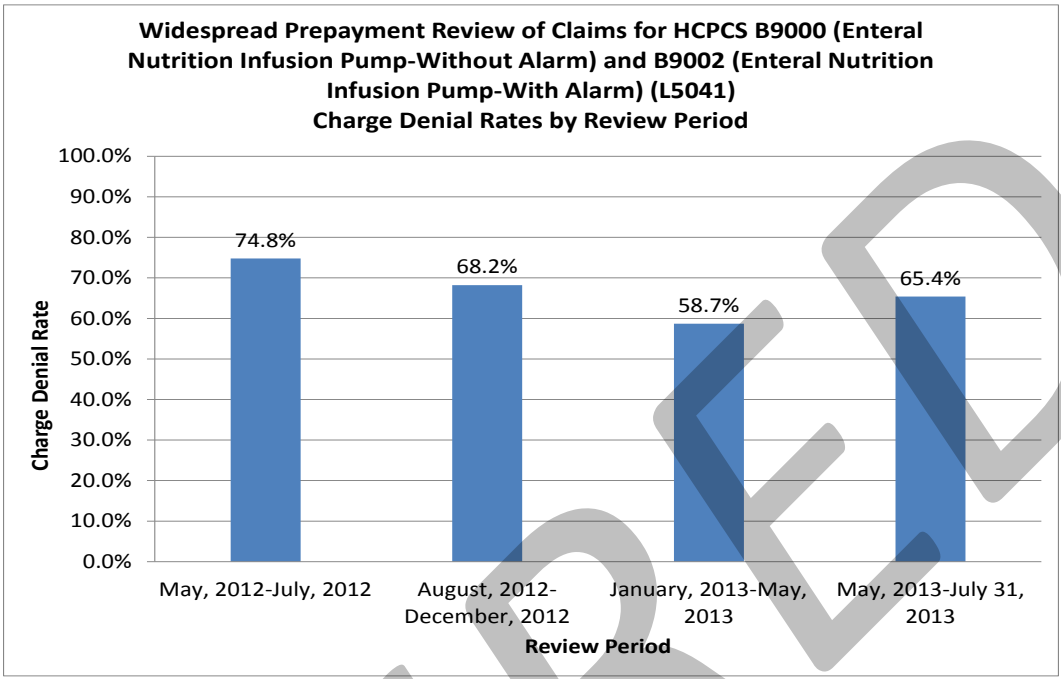
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed January 1, 2013 thru May 30, 2013 and resulted in a 58.7% Charge Denial Rate (CDR).

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 and B9002. These findings include claims processed primarily from May 1, 2013 through July 31, 2013.

The review involved prepayment complex medical review of 717 claims submitted by 154 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 303 (42%) of the claims. For the remaining 414 claims, 139 claims were allowed and 275 were denied/partially denied resulting in a claim denial rate of 66%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 65.4%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

Based on review of the documentation received, the following are the primary reasons for denial. Note that the percentages noted below reflect the fact that a claim could have more than one missing/incomplete item:

Clinical Documentation Issues

- 70.7 % of the denied claims did not have any medical record documentation submitted.
- 5.2% of the denied claims had insufficient clinical documentation to justify the LCD criteria.
    a. a permanent non-function or disease of the structures that normally permit food to reach the small bowel
    b. a disease of the small bowel which impairs digestion and absorption of an oral diet.

  Note: *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 3.6 % of the claims denied for statutory denial - does not meet prosthetic benefits requirement.

Proof of Delivery

- 7.3% of the denied claims had no Proof of Delivery

Detailed Written Order Issues

- 9.3 % of the denied claims had missing detailed written orders.
- 5.2 % of the denied claims had incomplete detailed written orders.
    - Date of the detailed order was incomplete (missing month or year)
    - Physician's signature could not be authenticated

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Enteral nutrition claims:

Example 1:

Received: The supplier submitted a valid DIF, clinical notes, detailed physicians order, valid proof of delivery

Missing: Clinical documentation stated that beneficiary was able to take in oral nutrition without any swallowing difficulty. Enteral Nutrition is covered under the prosthetic . benefit, therefore this is a statutory denial - does not meet benefit requirement

Example 2:

Received: DIF and Delivery ticket, Detailed physician order
Missing: Prescribing physician progress notes that determine if the physician has been treating the pt and that support the policy coverage criteria for enteral nutrition and the infusion pump per the LCD L5041

Example 3:

Received: A detailed written order from the physician and a completed DIF, clinical notes and delivery ticket
Missing: Clinical documentation from physician demonstrating that the beneficiary has a permanent non-function or disease of the structures that normally permit food to reach the small bowel or a disease of the small bowel which impairs digestion and absorption of an oral diet.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for B9000 and B9002.

DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews. One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs).

When a supplier achieves and maintains high quality accuracy and ADR response rate over three (3) quarterly periods, the supplier will be temporarily removed from that particular widespread review. The supplier's authorized official will be notified and provided details of this decision.

Questions and comments can be sent to the DME MAC Jurisdiction A Provider Compliance mailbox at:
dme_mac_jurisdiction_a_provider_compliance@hp.com

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for Enteral nutrition claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- Enteral Nutrition (L5041) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (issued 6/23/13, 3/8/2013, 7/20/2012, 05/11/12, 12/22/12, 09/20/11, and 03/11/11)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx

- CERT Physician Letter - Enteral Nutrition
  http://www.medicarenhic.com/dme/phyletters.aspx

- Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/selfservice.aspx

- Frequently Asked Questions (search word Enteral)
  http://www.medicarenhic.com/faqs.aspx?categories=DME

- Enteral Nutrition Supply Kits - Coverage Reminder
  http://www.medicarenhic.com/viewdoc.aspx?id=563

- Monthly CERT Error examples
  http://www.medicarenhic.com/dme/dmerccertrec.aspx

Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (SPE)

Historical Review Results

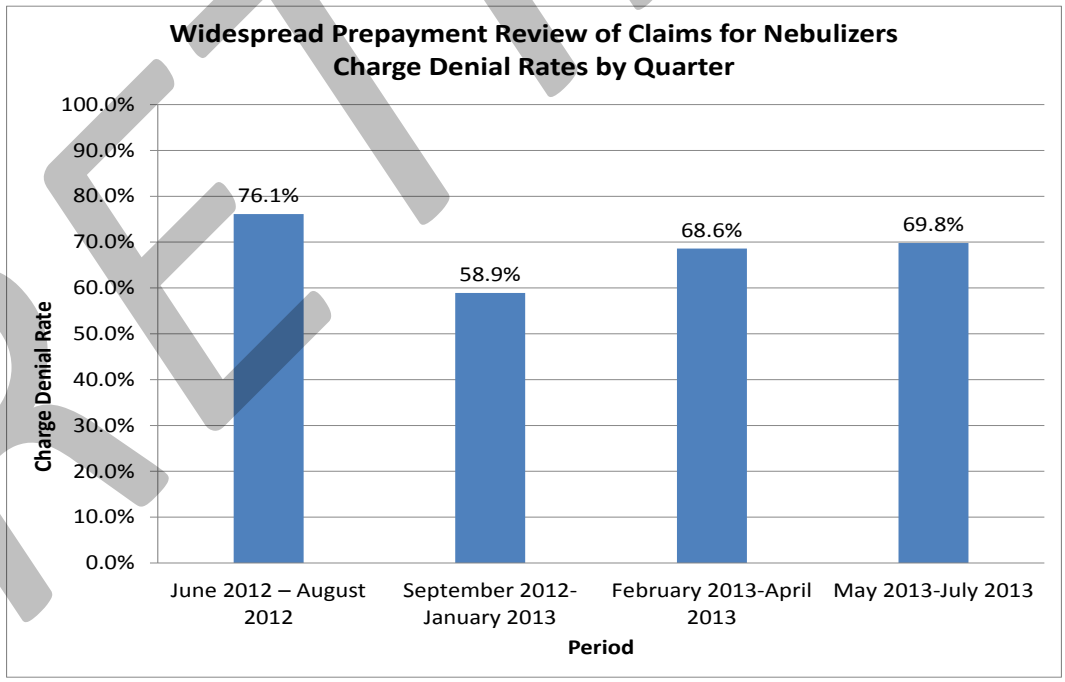
DME MAC A Medical Review continues to review Nebulizers, with Compressor, based on the results of previous quarterly findings. The previous quarterly findings covered the period of February, 2013 through April 30, 2013 and resulted in a Charge Denial Rate (CDR) of 68.6%

Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from May 2013 through July 31, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 397 claims submitted by 252 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 171 (43%) of the claims. For the remaining 226 claims, 80 claims were allowed and 146 were denied/partially denied resulting in a claim denial rate of 64.6%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate (CDR) of 69.8%.

Charge Denial Rate Historical Data
The following data depicts the Charge Denial Rate from previous quarters to current:



Reasons for Denial

Based on review of the documentation received, the following are the reasons for denial. Note that the percentages detailed below reflect the fact that a claim could have more than one missing/incomplete item, also note that claims can be denied for multiple reasons therefore the percentages of reviews may not add up to 100%:

Clinical Documentation Issues

- 72.4% of the denied claims were missing any clinical information to support medical necessity.
- 6.6% No documentation submitted at all, no clinical notes, no physician order, no delivery ticket

Detailed Written Order Issues

- 7.1% of the denied claims were missing the detailed written order.
- 4.6% of the denied claims had an incomplete or invalid detailed written order. The following are specific issues identified:
    - Illegible copy of order
    - Start date or the date of physician signature was after the date of service and no dispensing order was submitted
    - Physician signature did not meet signature requirements; illegible Physician signature and unable to authenticate Physician signature with printed name and no signature log submitted.

Proof of Delivery Issues

- 9.1% of the denied claims were missing proof of delivery.
- 0.5% of the denied claims had an incomplete or invalid proof of delivery. The following are specific issues identified:
    - Illegible copy of proof of delivery
    - Nebulizer delivered to the beneficiary prior to the date of service of the claim
    - Missing sufficiently detailed description to identify the item(s) being delivered
    - Missing beneficiary signature and date of signature when item(s) are delivered directly by the supplier

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with nebulizer claims:

Example 1:

Received: Detailed order with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature; Clinical notes and proof of delivery.
Missing: Clinical notes do not explain reasonable and necessary use of a nebulizer. In instances where the nebulizer and supplies are delivered directly by the supplier, the date the beneficiary received the nebulizer device and supplies must be the date of service on the claim. The date of delivery for this claim was before the date of service.

Example 2:

Received: Detailed order with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature, proof of delivery to support the item ordered was received by the beneficiary
Missing: Order submitted was dated after the date of service and there was no dispensing order submitted. No clinical notes to support reasonable and necessary use of a nebulizer.

Example 3:

Received: Detailed order, proof of delivery with: beneficiary name and address, description of item to be delivered.
Missing: Illegible copy of order submitted. No clinical notes to support reasonable and necessary use of a nebulizer. No proof of delivery to support the item had been received by the beneficiary.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for E0570 (Nebulizer, with Compressor).

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews. One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs).
When a supplier achieves and maintains high quality accuracy and ADR response rate over three (3) quarterly periods, the supplier will be temporarily removed from that particular widespread review. The supplier's authorized official will be notified and provided details of this decision.

Questions and comments can be sent to the DME MAC Jurisdiction A Provider Compliance mailbox at:
dme_mac_jurisdiction_a_provider_compliance@hp.com

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for nebulizer claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective February 2011 (A24944)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- Results of Widespread Prepayment Review of Claims for E0570: posted November 11, 2010, March 25, 2011, July 01, 2011, December 22, 2011, April 20, 2012, August 17, 2012, December 06, 2012, and March 15, 2013, June 13, 2013
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx

- CERT Physician Letter - Nebulizers
  http://www.medicarenhic.com/dme/phyletters.aspx

- Monthly CERT Error examples
  http://www.medicarenhic.com/dme/dmerccertrec.aspx

- Frequently Asked Questions (search word "nebulizer")
  http://www.medicarenhic.com/faqs.aspx?categories=DME

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

Historical Review Results

DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of the previous review findings. The previous quarterly findings covered claims reviewed from April 2013 through June 2013 and resulted in a 66.7% Charge Denial Rate (CDR).

Current Review Results

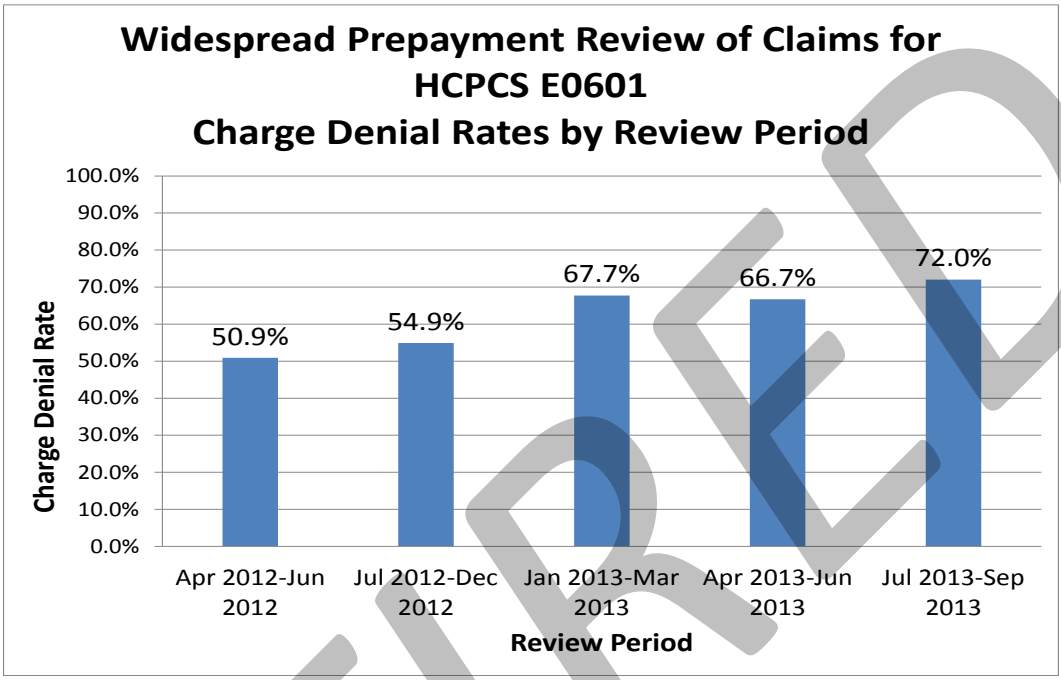
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from July 2013 through September 2013. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 1,300 claims submitted by 426 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 200 (15%) of the claims. Of the 1,100 claims for which responses were received, 304 claims were allowed and 796 were denied/partially denied. This resulted in a claim denial rate of 72.3%. The total

denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 72.0%.

Charge Denial Rate Historical Data

The following graph depicts the Charge Denial rate from previous periods to current:



Primary Reasons for Denial

Based on the review of the documentation received, the following are the primary reasons for denial. Note that the percentages below reflect the fact that a claim could have more than one missing/incomplete item:

Face-to-Face Clinical Evaluation Documentation Issues

- 24.6% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
    - These claims had no Face-to-Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement. Scenarios included are as follows:
        A. Beneficiaries seeking initial coverage of a PAP device.
        B. Beneficiaries seeking PAP replacement following the 5 year RUL
        C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare.

- 29.5% of the denied claims had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. The insufficient clinical documentation included:
    - Clinical documentation provided did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing presenting symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
    - Face-to-Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued benefit from sleep therapy.
    - Insufficient clinical documentation noted in Face-to-Face evaluations conducted by the treating physician in claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering Fee-for-Service (FFS) Medicare.

- 6.4% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 2.8% of the denied claims had illegible Face-to-Face documents.

Detailed Written Order Issues

- 2.7% of the denied claims did not include the Detailed Written Order.
- 14.5% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 0.8% of the denied claims had a Detailed Written Order which was illegible.
- 1.6% of the denied claims had Detailed Written Orders which were not dated.

Sleep Study Documentation Issues

- 7.6% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 1.6% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 13.8% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.
- 0.6% of the denied claims had Sleep Study documents which were illegible.

Training Documentation Issues

- 22.4% of the denied claims did not include evidence of training on the PAP device.
- 5.7% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face-to-face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 4.5% of the denied claims were missing Proof of Delivery.
- 8.6% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature and date of signature.
- 1.3% of the denied claims were delivered after the Date of Service.
- 3.4% of the denied claims were delivered before the Date of Service.

Claim Examples

As an additional educational effort, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the common documentation errors that may occur with CPAP claims:

Example 1:

Received: Included in this claim are a Detailed Written Order, a Medicare approved Home Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: There is no Face-to-Face clinical evaluation prior to the Home Sleep Study to assess the beneficiary for signs/symptoms of sleep apnea. There is no evidence beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. The Detailed Written Order does not list all items separately billed or refill/replacement instructions.

Example 2:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The Face-to-Face clinical evaluation was not conducted before the Medicare approved Sleep Study.

Example 3:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written order, a Medicare approved Sleep Study, Proof of Delivery, and evidence of training on the PAP device.
Missing: The Sleep Study findings did not meet the coverage criteria outlined in the PAP Local Coverage Determination.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed for Continuous Airway Pressure Devices (E0601).

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

NHIC appreciates the hard work by suppliers that has resulted in improvements in the error rate over the past year. We encourage all suppliers to continue to examine E0601 claims for compliance with all of the LCD requirements.

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E0601 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528) LCD and Policy Article (A19815)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601): Posted 8/30/2013, 5/31/2013, 2/28/2013, 11/30/2012, 8/24/2012, 04/20/2012, 12/22/2011, 08/19/2011, 3/04/2011 and 7/02/2010
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding general coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx

- CERT Physician Letter - Positive Airway Pressure (PAP) Devices
  http://www.medicarenhic.com/dme/phyletters.aspx

- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/dmerccertrec.aspx

- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerccertrec.aspx

- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faqs.aspx?categories=DME

Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (MOB)

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from January 01, 2013 through March 31, 2013 and resulted in an 86.6% Charge Denial Rate (CDR).

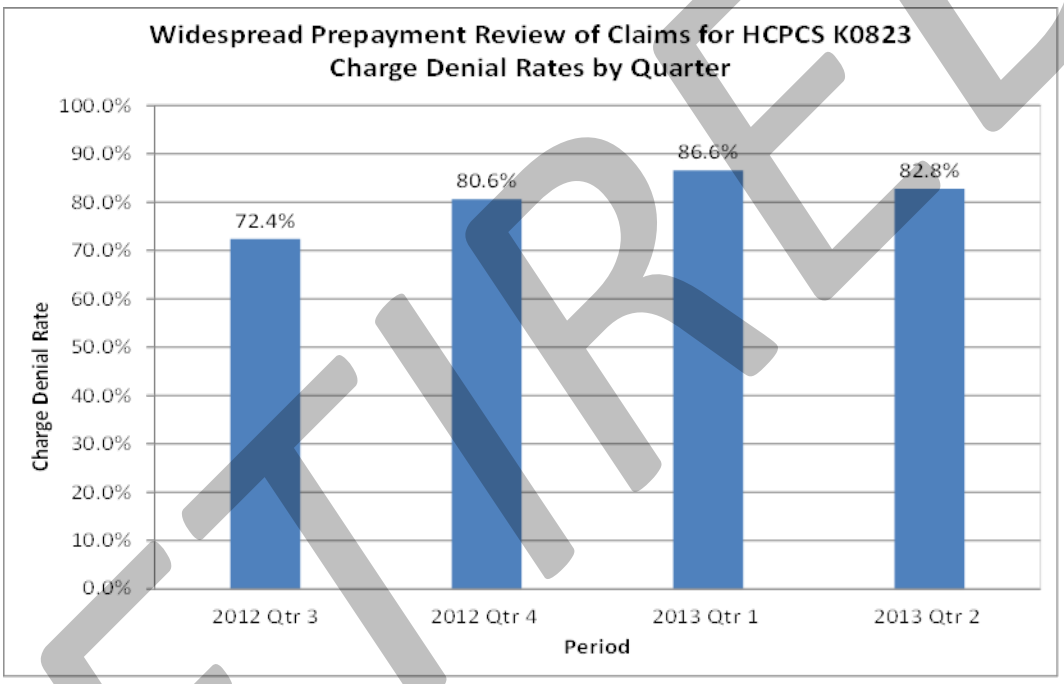
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings include claims with dates processed from April 01, 2013 through June 30, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 201 claims submitted by 109 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 53 (26%) of the ADR requests issued. Of the 148 claims for which responses were received, 22 of the claims were allowed and 126 of the claims were denied. This resulted in a claim denial rate of 85%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 82.8%.

Charge Denial Rate Historical Data

The following graph depicts the Charge Denial Rate from previous quarters to current:



Primary Reasons for Denial

Based on the review, the following are the primary reasons for denial. Note that the percentages below reflect the fact that a claim could have more than one missing/incomplete item.

Face-to-Face Medical Documentation

- 11% of the denied claims had insufficient clinical documentation to support medical necessity:
  - 2% The Face-to-Face did not contain a comprehensive medical examination.
  - 4% The Face-to-Face examination received was insufficient to establish that one of the major reasons for the examination was for a mobility evaluation.
  - 2% The Face-to-Face examination did not specify the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) within their home.
  - 2% The Face-to-Face examination fails to specify that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs).
  - 1% The Face-to-Face examination did not indicate that the beneficiary has the physical and/or mental capability to safely operate the power mobility device being requested.
- 5% of the denied claims did not include confirmation the supplier received a copy of the Face

- To Face Clinical Evaluation within 45 days of the completion of the Face-to-Face exam; as verified by a supplier date stamp or equivalent.
- 4.5% of the denied claims were missing the Face-to-Face Clinical Evaluation.
- 2.5% of the denied claims did not have the treating physician's signature on the Face-to-Face Clinical Evaluation.
- 1.5% of the denied claims did not have the treating physician's signature date on the Face-to-Face Clinical Evaluation.
- 1% of the denied claims included a Face-to-Face Clinical Evaluation that was completed on a limited space template with an insufficiently detailed or incomplete narrative from the physician, and without documentation in the physician's medical record.

7-Element Order

- 7.5% of the denied claims did not include confirmation the supplier received a copy of the 7-Element Order within 45 days after the completion of the Face-to-Face Clinical Evaluation as verified by a supplier date stamp or equivalent. A date stamp or equivalent was not present.
- 3.5% of the denied claims were missing an element of the 7-Element Order:
    - 2.5% The 7-Element order contains an invalid date of the Face-to-Face examination.
    - 1% The 7-Element order is missing the date of Face-to-Face examination.

LCMP Examination

- 14% of the denied claims did not include a signed and dated attestation by the supplier or licensed/certified medical professional (LCMP) stating they have no financial relationship with the supplier.
- 5.5% of the denied claims were missing the treating physician's signature date on the LCMP Examination.
- 4.5% of the denied claims did not include confirmation the supplier received a copy of the LCMP Examination within 45 days of the completion of the Face-to-Face exam; as verified by a supplier date stamp or equivalent.
- 3% of the denied claims contained medical documentation in which the treating physician did not state concurrence with the LCMP Examination, either in the Face-to-Face documentation or by indicating concurrence with a dated signature on the LCMP Examination.
- 3% of the denied claims were missing the OT/PT Signature and/or Signature Date on LCMP Examination.

Detailed Product Description (DPD)

- 9% of the denied claims did not contain enough information to determine that the item was properly coded.
- 6.5% of the denied claims did not include a DPD.
- 5.5% of the denied claims did not include confirmation the supplier received a copy of the DPD prior to the delivery of the power wheelchair, as verified with a date stamp or equivalent from the supplier.
- 2% of the denied claims had the DPD dated prior to the physician's signature on the 7-Element Order.
- 1.5% of the denied claims did not have the treating physician's signature date on the DPD1% of the denied claims had a DPD that was dated after the date of service.

Proof of Delivery

- 6.5% of the denied claims had items listed on the delivery ticket that did not match the items listed on the (DPD) and/or the ADS letter.
- 5% of the denied claims contained an ADS letter billing a K0823 and then supplied a Proof of Delivery that documented a different power wheelchair was delivered.
- 2.5% of the denied claims did not include the beneficiary's signature on the Proof of Delivery.
- 2% of the denied claims contained a Proof of Delivery in which the delivery date did not match the Date of Service.
- 1.5% of the denied claims were missing a Proof of Delivery.
- 1.5% of the denied claims were missing the beneficiary's signature or the Proof of Delivery.

Home Assessment

- 5% of the denied claims did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair.
- 2.5% of the denied claims had home assessments that were not dated by either the supplier or the practitioner.
- 1.5% of the denied claims were missing a supplier's signature on the Home Assessment.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

Example 1

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Clinical Evaluation, Detailed Product Description, Home Assessment and Proof of Delivery.
Missing: The Face-to-Face examination did not include documentation that demonstrated the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) within their home as well as limitation of upper extremity function was insufficient to self-propel an optimally-configured manual wheelchair in the home. The Home Assessment did not include the date the assessment took place or the signature of the supplier representative that performed the assessment.

Example 2

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Clinical Evaluation, LCMP Examination, Detailed Product Description, Home Assessment and Proof of Delivery.
Missing: The Face-to-Face Clinical Evaluation, 7-Element and LCMP Examination not include confirmation that the supplier received a copy of these documents within 45 days of the completion of the Face-to-Face Evaluation as verified with a date stamp or equivalent from the supplier. The Detailed Product Description did not include confirmation that the supplier received a copy prior to the delivery of the power wheelchair, as verified with a date stamp or equivalent from the supplier. The documentation does not include a signed and dated attestation by the supplier or licensed/certified medical professional (LCMP) stating they have no financial relationship with the supplier.

Example 3

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Clinical Evaluation, Detailed Product Description, Home Assessment and the Proof of Delivery.
Missing: The Face-to-Face examination did not include documentation that demonstrated the beneficiary's limitation of upper extremity function was insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs). The Home Assessment did not include the date the assessment took place. The Detailed Product Description did not include the manufacturer name/make/model of the item being requested and therefore it could not be determined if item was correctly coded.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS K0823.

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews. One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs).

When a supplier achieves and maintains high quality accuracy and ADR response rate over three (3) quarterly periods, the supplier will be temporarily removed from that particular widespread review. The supplier's authorized official will be notified and provided details of this decision.

Questions and comments can be sent to the DME MAC Jurisdiction A Provider Compliance mailbox at:
dme_mac_jurisdiction_a_provider_compliance@hp.com

Educational References

NHIC Corp. DME MAC and CMS provide extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerccertrec.aspx

- Power Mobility Devices (L21271) LCD
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- Power Mobility Devices - 7-Element Order (published 11/05/2009)
  http://www.medicarenhic.com/viewdoc.aspx?id=560

- Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios (published 04/05/2013)
  http://www.medicarenhic.com/viewdoc.aspx?id=1591

- Power Mobility Devices Billing Reminder (published 01/11/2008)
  http://www.medicarenhic.com/viewdoc.aspx?id=206

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
  http://www.medicarenhic.com/dme/supmandownload.aspx

- Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (published 06/28/2013, 03/28/2013, 12/20/2012, 09/28/2012, 07/13/2012, 04/20/2012, 12/15/2011, 08/26/2011, 06/10/2011, 03/11/2011, and 11/05/2010)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Frequently Asked Questions (search word PMD)
  http://www.medicarenhic.com/faqs.aspx?categories=DME

- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network; ICN 905063 September 2011)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf

- Power Mobility Device Face-to-Face Examination Checklist (SE1112)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf

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Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment, HCPCS E1390, E0431, and E0439 (OXY)

Historical Review Results

DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of March 01, 2013 through May 31, 2013 and resulted in a 54.5% Charge Denial Rate (CDR).

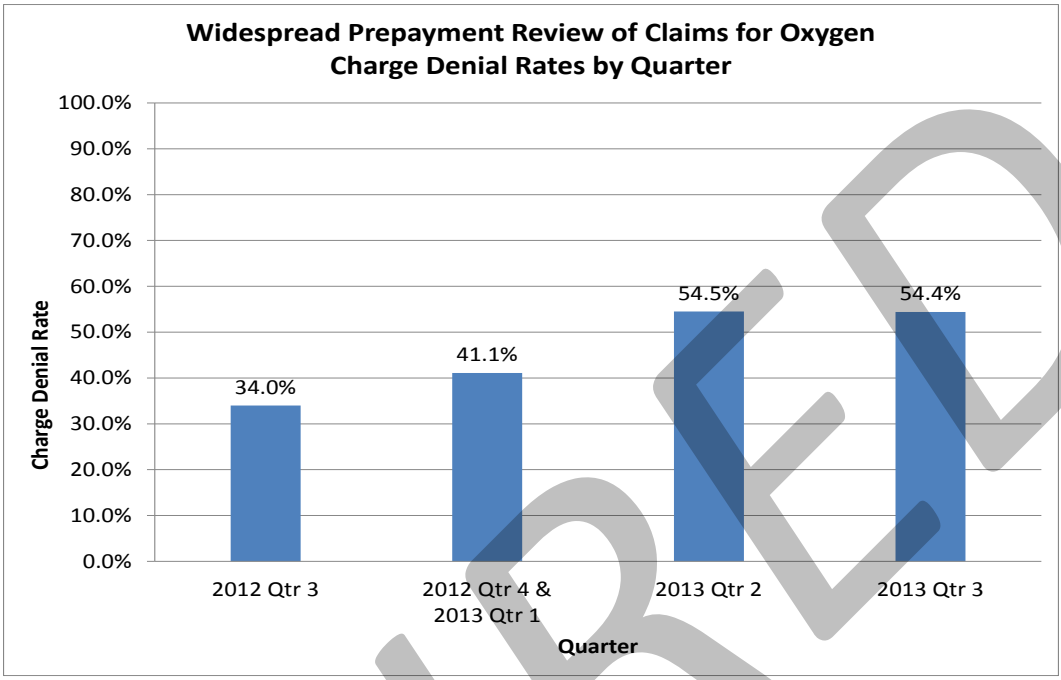
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from June 01, 2013 through September 30, 2013.

The review involved prepayment complex medical review of 737 claims submitted by 155 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 153 (21%) of the claims. For the remaining 584 claims, 280 claims were allowed and 304 were denied resulting in a claim denial rate of 52%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 54.4%.

Charge Denial Rate Historical Data

The following graph depicts the Charge Denial rate from previous quarters to current:



The Indications and Limitation of Coverage and/or Medical Necessity section of the Oxygen and Oxygen Equipment LCD states:

> Home oxygen is covered only when both the reasonable and necessary and statutory criteria are met as outlined in the LCD and Policy Article. Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:
>
> 1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
>
> 2. The patient's blood gas study meets the criteria stated in the LCD, and
>
> 3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and
>
> 4. The qualifying blood gas study was obtained under the following conditions:
>   a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
>   b. If the qualifying blood gas study is not performed during an inpatient 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, and
>
> 5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11468 and related Policy article for additional information.

Primary Reasons for Denial

Based on review of the documentation received, the following are the primary reasons for denial.

Missing Documentation (81%):

Missing required physician visit per Local Coverage Determination (LCD) L11468:

- 42% of the denied claims were missing treating physician visits - 30 days prior to the initial date of service
- 1% of the denied claims were missing treating physician visits - 90 days prior to the recertification date

Missing qualifying blood gas study per LCD L11468:

- 24% - No documentation to validate oxygen testing

Missing required Certificate of Medical Necessity per LCD L11468:

- 2% - Missing an Initial CMN or the Initial CMN was incomplete

Missing valid proof of delivery per LCD L11468:

- 12% - Missing valid delivery ticket

Clinical Documentation Issues: Medical Necessity could not be established (19%):

Clinical documentation did not support criteria of LCD L11468 for the following reasons (12%):

- No indication in medical documentation of presence of severe lung disease or hypoxia related symptoms
- Medical documentation does not demonstrate that beneficiary was tested in a chronic stable state
- Signature requirements were not met
- Documentation submitted was illegible
- Documentation did not demonstrate that beneficiary was mobile within the home to qualify for use of a portable device

Clinical documentation did not support criteria indicated on CMN for the following reasons (7%):

- Exercise testing did not qualify for Group I testing criteria - documentation did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy
- Blood gas study performed during sleep did not demonstrate that saturation was at or below 88% for at least 5 minutes
- Saturation criteria for a flow rate greater than 4 LPM was not met

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with Oxygen therapy claims.

Example 1:
DOS: 3/11/13
Code(s) Billed: E1390, E0431

Documentation received: Dispensing order dated 3/7/13, initial CMN dated 3/7/13, documentation of a physician's visit dated 3/7/13 including documentation of the beneficiary's saturation exercising on room air to validate the saturation results provided on the CMN, delivery ticket dated 3/7/13, assignment of benefits form, health insurance claim form

Missing: Documentation of testing at rest on room air and while exercising with oxygen applied to meet the criteria for exercise testing, delivery ticket dated 3/11/13

Example 2:
DOS: 12/13/12
Code(s) Billed: E1390

Documentation received: Patient notes forms from supplier, complete physician's order signed and dated 12/12/13, initial CMN dated 12/13/12, documentation of a physician visit dated 1/3/13, rental/sales agreement form, delivery ticket dated 12/12/12

Missing: Documentation of a physician visit dated within 30 days prior to the initial date of service, documentation of a blood gas study in the medical records to validate the blood gas study results provided on the initial CMN, delivery ticket dated 12/13/12

Example 3:
DOS: 1/29/13 - 5/29/13
Code(s) Billed: E1390, E0431

Documentation received: Delivery ticket dated 1/28/13, rental/purchase agreement form, oxygen concentrator orientation checklist, equipment orientation checklist, complete physician's order signed and dated 1/28/13, documentation of a physician visit dated 1/24/13, initial CMN dated 1/28/13

Missing: Documentation in the medical record demonstrating that the beneficiary has a severe lung disease or hypoxia-related symptoms, delivery ticket dated 1/29/13

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS E1390, E0431 and E0439.

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768) **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- The *DME MAC Jurisdiction A Supplier Manual* **http://www.medicarenhic.com/dme/supmandownload.aspx**
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.

- CERT Error Articles - Monthly publications **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- CERT Physician Letter - Oxygen & Supplies **http://www.medicarenhic.com/dme/phyletters.aspx**

- Frequently Asked Questions (search word oxygen) **http://www.medicarenhic.com/faqs.aspx?categories=DME**

- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: August 30, 2013, May 17, 2013, February 08, 2013, October 12, 2012, June 29, 2012, March 02, 2012, November 04, 2011, August 26, 2011, November 05, 2010, and June 09, 2010). **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390 **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

Walker Unbundling Billing for Brakes (MOB)

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

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

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

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

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

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

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

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

Refer to the Walkers LCD and related Policy Article (**http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**) for additional information about coverage, documentation and coding requirements.

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

Third Quarter 2013 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2013 are provided in the following table.

Note: *The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.*

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 Rejected for relational field Information within the HCPCS	110,710	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.094.2010AA.REF02.050 Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	31,084	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	23,308	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.087.2010AA.NM109.050 Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	16,764	The NPI submitted is not linked to the Submitter ID under which the claim file was sent. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site and return to CEDI for processing.
X222.380.2400.DTP03.090 Invalid Information within the Date(s) of service	11,654	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
X222.087.2010AA.NM109.030 Invalid information in the Billing Provider's NPI	11,265	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.380.2400.DTP03.080 Invalid Information within the Future date and Date(s) of service	10,675	The service start/from date is greater than the date this claim was received.
X222.226.2300.HI01-2.030 Invalid Information within the Primary diagnosis code	10,372	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.351.2400.SV101-3.020 This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	9,113	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.351.2400.SV101-7.020 This Claim is rejected for relational field Information within the Detailed description of service	6,709	Description must be present when Procedure Code requires a description/additional information.

Third Quarter 2013 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the third quarter of 2013. Claims denied in this manner are considered to be unprocessable and have no appeal

rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from July through September 2013.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	32,340
OA109, N104 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	13,450
CO 182 N56 Procedure modifier was invalid on the date of service	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	10,578
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	1,707
CO 16 M79 Missing/incomplete/invalid charge.	**Item 24F** - Did not complete or enter the appropriate charge for each listed service (submitted charges zero).	1,587
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,463
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	1,456
CO16 N350 Claim/service lacks information which is needed for adjudication.	**Item 19** - Missing / incomplete / invalid description of service for a Not Otherwise Classified (NOC) code.	1,452
CO 140 Patient health identification number and name do not match.	**Item 1A** - This error is received when the patient's health identification number and name do not match.	1,447
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	1,435

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above charts and share it with your colleagues.

DME MAC A's Gift Policy (GEN)

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DME MAC A has a zero tolerance policy

regarding gifts - we cannot accept any. If you would like to express your thanks for service you have received from DME MAC A's representatives, we welcome notes or letters of appreciation in place of gifts.

2014 Jurisdiction A DME MAC Holiday Schedules (GEN)

The **Jurisdiction A Offices** will be observing the following holidays in 2014:

Holiday	Day of the Week	Date
New Year's Day	Wednesday	January 1
Martin Luther King, Jr. Day	Monday	January 20
Memorial Day	Monday	May 26
Independence Day	Friday	July 4
Labor Day	Monday	September 1
Veterans Day	Tuesday	November 11
Thanksgiving Day	Thursday	November 27
Friday following Thanksgiving	Friday	November 28
Christmas Day	Thursday	December 25
Company-designated Floating Holiday	Friday	December 26

The **Jurisdiction A Call Center** will be observing the following holidays in 2014:

Holiday	Day of the Week	Date
New Year's Day	Wednesday	January 1
Martin Luther King, Jr. Day	Monday	January 20
Memorial Day	Monday	May 26
Independence Day	Friday	July 4
Labor Day	Monday	September 1
Columbus Day	Monday	October 13
Thanksgiving Day	Thursday	November 27
Day after Thanksgiving	Friday	November 28
Christmas Day	Thursday	December 25

Supplier Manual News (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) *Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/publications.aspx**. After accepting the CPT License Agreement, suppliers can access the entire DME MAC A *Supplier Manual*, including revised chapters and archived revisions. The *Supplier Manual* is available to current suppliers via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Updates/Corrections Made:

In September of 2013 chapters 3, 10, and 12 of the *DME MAC A Supplier Manual* were updated. In October 2013 all chapters of the *Supplier Manual* were updated with new web site links. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at **http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html**. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

Updating Supplier Records (GEN)

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information must be reported in writing to the NSC within 30 days after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier must then verify their address with the NSC in writing.

Note: *A request to change your address should not be sent to DME MAC A since we cannot change supplier files.*

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms web site at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html** to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC A ListServes (GEN)

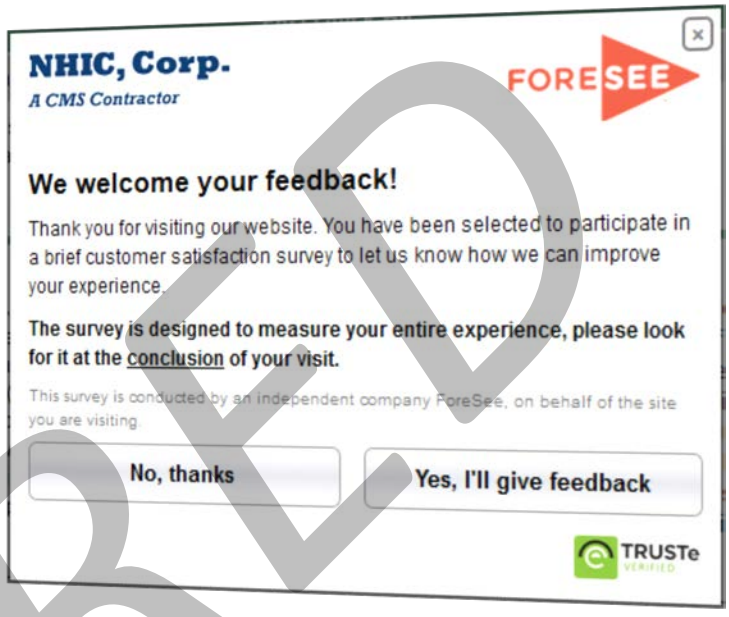
The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly Bulletins and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at **http://www.medicarenhic.com/dme/listserve.html**

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey

NHIC, Corp. DME MAC Jurisdiction A is committed to ensuring that our Web site meets the needs of our users. We continually strive to improve our offerings based on the information and feedback we receive from you. In order to accomplish this, we offer *The DME MAC A Web site Customer Satisfaction Survey*. This survey is designed to collect information that helps measure providers' satisfaction with contractors' Web sites with a focus on customer service.



If you see the **Customer Satisfaction Survey** pop up while you are browsing the DME MAC A Web site, please take a moment to participate. Completion should only take a few minutes.

As our site is constantly changing, we would appreciate your input! We are listening... It is **your** feedback that makes those changes possible!

Thank you for taking the time to provide us with your comments! Remember, it is your feedback that makes changes possible in order to address your Medicare needs!

Customer Service should be your first means of contact for any questions or issues you have that cannot be addressed by the IVR. To speak with a Customer Service Representative directly call: **866-590-6731**

Helpful Contacts

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

Outreach & Education

outreach-education@hp.com

Claims Submissions

DME Jurisdiction A Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
Written Inquiry FAX: 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Overpayments

Refund Checks:
NHIC, Corp.
P.O. Box 809252
Chicago, IL 60680-9252

Payment Offset Fax Requests: 781-741-3916

Note: *Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

Redetermination Requests Fax: 781-741-3118

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Reconsiderations:
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
301 W Bay St.
6th Floor
Jacksonville, FL 32202-5100

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:
NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:
Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: **ngs.CEDIHelpdesk@wellpoint.com**

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DME MAC Jurisdiction A Resource

INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT

December 2013
Number 30

Publication Information

NHIC, Corp. is the contractor for the Jurisdiction A DME MAC serving all of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Visit the following websites for more information:

NHIC, Corp.: www.medicarenhic.com/dme

TriCenturion: www.tricenturion.com

CMS: www.cms.gov

The *DME MAC Jurisdiction A Resource*, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

DME MAC Jurisdiction A Resource Coordinator
Outreach & Education Publications
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
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