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

June 2013
Number 28

General Announcements

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:
www.medicarenhic.com/dme/

Table of Contents

Medical Review

Outreach & Education

Table of Contents

Legend

DRU	Drugs	**O&P**	Orthotics & Prosthetics	**SPE**	Specialty Items
GEN	General	**OXY**	Oxygen	**VIS**	Vision
MOB	Mobility/Support Surfaces	**PEN**	Parenteral/Enteral Nutrition		

***MLN Matters* Disclaimer**
These articles were prepared as a service to the public and are not intended to grant rights or impose obligations. These articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Calendar Year 2013 Update to the Amount in Controversy Requirements for Administrative Law Judge and Federal District Court Appeals (GEN)

The *Medicare Prescription Drug, Improvement, and Modernization Act* requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review.

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2012, is $130. This amount increases to $140 for ALJ hearing requests filed on or after January 01, 2013. The amount that must remain in controversy for Federal District Court review requests filed on or before December 31, 2012 is $1,350. This amount increases to $1,400 for appeals to Federal District Court filed on or after January 01, 2013.

Appeal Level	Time Limit for Filing	Monetary Threshold
Redetermination	120 days from date of receipt of the notice of the initial determination	None
Reconsideration	180 days from the date of receipt of the redetermination	None
Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	At least $140
Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
Federal Court Review	60 days from the date of receipt of DAB decision or review by DAB	At least $1,400

For more information about the Appeals process and Amount in Controversy review **Chapter 8 (Reopenings and Appeals)** of the *DME MAC A Supplier Manual* available on the DME MAC A Web site at:
http://www.medicarenhic.com/dme/suppmandownload.shtml

Claim Status Category and Claim Status Codes Update (MM8265) (GEN)

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

Note: *This article was revised on April 30, 2013, to revise the news flash (above) to show the Phase 2 edits are delayed. All other information remains the same.*

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8265, from which this article is taken, requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277

transactions) to report the status of your submitted claim(s). **Proprietary codes may not be used in the X12 276/277 to report claim status.**

All code changes approved during the January 2013 Committee meeting will be posted on or about March 1, 2013, at **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes** and **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes** and are to be reflected in the X12 277 transactions issued on and after the date of implementation of CR8265 (July 1, 2013).

Background

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

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on and after the date of implementation of CR8265 (July 1, 2013), your Medicare contractor must: 1) Complete the entry of all applicable code text changes and new codes; 2) Terminate the use of deactivated codes; 3) Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.

Additional Information

The official instruction, CR8265 issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2681CP.pdf** on the CMS website. If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or 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.

Claim Status Category and Claim Status Codes Update (MM8320) (GEN)

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8320 which requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

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

Background

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

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

1. Complete the entry of all applicable code text changes and new codes;
2. Terminate the use of deactivated codes;
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, CR8320 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2713CP.pdf** on the CMS website. 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.

Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual (MM8121) (GEN)

MLN Matters® Number: MM8121
Related CR Release Date: March 29, 2013
Related CR Transmittal #: R2678CP

Related Change Request (CR) #: CR 8121
Effective Date: April 29, 2013
Implementation Date: April 29, 2013

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

Please be aware that Medicare contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors will check the diagnosis. If the diagnosis codes are duplicates, contractors will request an explanation before making payment. The official instruction for CR8121

spells out what your Medicare contractor looks for when analyzing the history of paid and pending claims, duplicate claims and the criteria for detecting suspect duplicate claims.

Background

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not.
For example, there are some Healthcare Common Procedure Coding System (HCPCS) modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The Level II modifiers "RT" and "LT," for example, indicate that a service was performed on the right and left side of the body, respectively.

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

Key Points of CR8121

Exact Duplicates

A. Submission of Institutional Claims

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

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

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

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

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

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

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

C. Claims Submitted by DMEPOS Suppliers

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

- HIC Number;
- From Date of Service;
- Through Date of Service;
- Place of service;
- HCPCS;
- Type of Service;
- Billed Amount; and
- Supplier.

Suspect Duplicates

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

A. Criteria for Detecting Suspect Duplicates on Institutional Claims

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

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

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

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

Additional Information

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

Clarify the Definition of Customized Durable Medical Equipment (DME) Items (MM8194) (GEN)

MLN Matters® Number: MM8194
Related CR Release Date: April 19, 2013
Related CR Transmittal #: R460PI and R2687CP

Related Change Request (CR) #: CR 8194
Effective Date: January 1, 1992
Implementation Date: July 19, 2013

Provider Types Affected

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

What You Need to Know

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

Background

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

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

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

Key Points

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

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

Additional Information

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

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 CR Release Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN

Related Change Request (CR) #: 6421, 6417, 6696, 6856
Effective Date: N/A
Implementation Date: N/A

Important Announcement on April 25, 2013: Temporary Delay in Implementing Ordering and Referring Denial Edits - Due to technical issues, the implementation of the Phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual National Provider Identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

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

CMS will advise you of the new implementation date in the near future. In the interim, informational messages will continue to be sent for those claims that would have been denied had the edits been in place. Language regarding beneficiary liability has also been updated in this version of the article.

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

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

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

Provider Action Needed

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

What Providers Need to Know

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

Important Announcement on April 25, 2013: Temporary Delay in Implementing Ordering and Referring Denial Edits - Due to technical issues, implementation of the Phase 2 denial edits is being delayed. These edits would have checked certain claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual National Provider Identifier (NPI). If this information were missing or incorrect, the following types of claims would deny:

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

Phase 2: CMS has not determined a date to turn on the Phase 2 edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits.

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

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

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI). The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;

- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A Home Health Agencies (HHA).

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

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

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

CMS would like to highlight the following limitations:

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

Questions and Answers Relating to the Edits

1. What are the ordering and referring edits?

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits were implemented in two phases:

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

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

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

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

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

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

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: In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. **CMS has not determined a date to turn on the Phase 2 edits.**

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

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

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims.

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

37236 - This reason code will assign when:

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

37237 - This reason code will assign when:

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

Effect of Edits on Providers

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

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

a. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
  - i. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - 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 carrier, A/B MAC, or DME MAC.

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

g. What if my claim is denied inappropriately?

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

h. How will the technical vs. professional components of imaging services be affected by the edits?

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

Additional Guidance

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

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

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

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

Additional Information

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

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

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

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.

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.

HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries (SE1249) (GEN)

MLN Matters® Number: SE1249 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 April 23, 2013, to update certain language to reflect the current status of this change. Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3.*

Provider Types Affected

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

Provider Action Needed

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

What You Need to Know

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

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's Health Care Eligibility Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key Points

General Information

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

HETS

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

Frequently Asked Questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?
No, but it is recommended. Providers may also choose to use a Medicare Contractor's IVR or Internet portal.

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

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

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

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

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

Additional Information

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

International Classification of Diseases (ICD)-10 Conversion from ICD-9 and Related Code Infrastructure of the Medicare Shared Systems as They Relate to CMS National Coverage Determinations (NCDs) (MM8197) (GEN)

MLN Matters® Number: MM8197 Revised
Related CR Release Date: March15, 2013

Related CR Transmittal #: R1199OTN

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

Note: *This article was revised on March 26, 2013, to add further information on accessing the spreadsheets attached to CR8197. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

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

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

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

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

Background

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

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

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

General Information Found in Spreadsheets in the Attachments

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

Each spreadsheet contains the following information:

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

Within each spreadsheet, there are three tabs:

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

Spreadsheets attached to CR8197 explain the following NCDs:

20.4	Implantable Automatic Defibrillator
20.7	Percutaneous Transluminal Angioplasty
20.16	Cardiac Output Monitoring by Thoracic Electrical Bioimpedance
20.30	Microvolt T-Wave Alternans
20.31	Intensive Cardiac Rehabilitation Programs
20.31.1	The Pritikin Program
20.31.2	Ornish Program for Reversing Heart Disease
40.1	Diabetes Outpatient Self-Management Training
40.7	Outpatient Intravenous Insulin Treatment
50.3	Cochlear Implantation
100.14	Surgery for Diabetes
110.4	Extracorporeal Photopheresis
110.8.1	Stem Cell Transplantation
150.10	Lumbar Artificial Disc Replacement
180.1	Medical Nutrition Therapy
190.1	Histocompatibility Testing
190.3	Cytogenetic Studies
190.5	Sweat Test
190.8	Lymphocyte Mitogen Response Assays
190.11	Home Prothrombin Time/International Normalized Ratio Monitoring for Anticoagulation Management
210.2	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
210.4	Smoking and Tobacco-Use Cessation Counseling
210.4.1	Counseling to Prevent Tobacco Use
210.7	Screening for the Human Immunodeficiency Virus Infection
210.10	Screening for Sexually Transmitted Infections and High-Intensity Behavioral Counseling to Prevent STIs
220.4	Mammograms
220.6.16	FDG PET for Infection and Inflammation
220.6.19	Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer
260.1	Adult Liver Transplantation
260.9	Heart Transplants

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

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

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

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

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

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

Additional Information

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

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

If you have any questions, please contact your carrier, FI, A/B MAC, or 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.

July 2013 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8247) (DRU)

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

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

Make sure that your billing staffs are aware of the release of these July 2013 ASP Medicare Part B drug files.

Background

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

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

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

Additional Information

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

July Quarterly Update for 2013 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8325) (GEN)

MLN Matters® Number: MM8325
Related CR Release Date: May 17, 2013

Related CR Transmittal #: R2439CP

Related Change Request (CR) #: CR 8325
Effective Date: January 1, 2013 - for implementation of fee schedule amounts for codes in effect on January 1, 2013; July 1, 2013 for all other changes
Implementation Date: July 1, 2013

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8325 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

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

Key Points of CR8325

- CR 8325 updates fees for Healthcare Common Procedure Coding System (HCPCS) codes E2378, L5859, and L7902. These HCPCS codes were added to the HCPCS file effective January 1, 2013. Previously these items were paid on a local fee schedule. If claims for these codes with dates of service on or after January 1, 2013 have already been processed, they will be adjusted to reflect the new fees if you bring the claims to your contractor's attention.

- As part of this update fee schedule amounts are also established for HCPCS code K0009 (Other Manual Wheelchair/Base). Payment on a fee schedule basis is mandated for all DME by section 1834(a) of the *Social Security Act* (the Act), other than items that meet the definition of customized DME at 42 CFR section 414.224 of the regulations. Effective July 1, 2013, payment for claims for manual wheelchairs, that receive a HCPCS code verification of K0009 by the Pricing Data Analysis

and Coding (PDAC) contractor, will be made on a capped rental basis with the fee schedule amounts established and updated in accordance with section1834 (a)(8) of the Act using data for all manual wheelchair codes effective in 1986.

Diabetic Testing Supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the *American Taxpayer Relief Act* (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act. The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

- A4233 Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4234 Replacement Battery, Alkaline, J Cell, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4235 Replacement Battery, Lithium, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4236 Replacement Battery, Silver Oxide, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4253 Blood Glucose Test or Reagent Strips for Home Glucose Monitor, Per 50 Strips.
- A4256 Normal, Low and High Calibration Solution / Chips.
- A4258 Spring-powered Device for Lancet, Each.
- A4259 Lancets, Per Box of 100.

Also, the fee schedule amounts for non-mail order diabetic supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted. The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law.
The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 are:

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

Effective July 1, 2013, only national mail order contract suppliers will be paid by Medicare for diabetic testing supplies other than those that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront. The single payment amount public use file for the national mail order competitive bidding program is available at **http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts** on the Internet.

Additional Information

The official instruction, CR 8325 issued to Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2709CP.pdf** on the CMS website.

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 Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) (MM7492) (GEN)

MLN Matters® Number: MM7492
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R950OTN

Related Change Request (CR) #: 7492
Effective Date: October 1, 2013
Implementation Date: January 1, 2012

Note: *This article was revised on March 27, 2013, to add a reference to article MM8207 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8207.pdf**) to alert DMEPOS providers and suppliers of modifications being made to the claims processing systems to report the appropriate NCD/LCD captured during claims processing based on their associations with either ICD-9 or ICD-10 diagnosis codes, the claim line service date, and the and the ICD-10 diagnosis code effective date.* ***This article was previously revised on March 21, 2013, to add a reference to article SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged.***

Provider Types Affected

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

Provider Action Needed

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

Key Points of CR7492

General Reporting of ICD-10

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

General Claims Submissions Information

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

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were

rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A - Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (*incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs))*	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health - Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home Health - (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A - Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82X	Hospice - Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice - Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

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

Table C - Professional Claims

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

Table D - Supplier Claims

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

Additional Information

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

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

If you have any questions, please contact your carrier, FI, RHHI, or 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 current information on the new ICD-10 implementation date of October 1, 2014, see article SE1239 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf** on the CMS website.

Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch (MM7260) (GEN)

MLN Matters® Number: MM7260
Related CR Release Date: March 14, 2013
Related CR Transmittal #: R2670CP

Related Change Request (CR) #: CR 7260
Effective Date: October 1, 2012
Implementation Date: April 1, 2013

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

Provider Types Affected

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

Provider Action Needed

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

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

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

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

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

Additional Information

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

National Competitive Bidding Program (CBP): Instructions for Processing CBP Oxygen and Capped Rental Durable Medical Equipment (DME) Claims with the Start of the Round One Recompete (MM8270) (OXY)

MLN Matters® Number: MM8270
Related CR Release Date: May 3, 2013
Related CR Transmittal #: R1219OTN

Related Change Request (CR) #: CR 8270
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

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

Provider Action Needed

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

Background

Section 302 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* ("Medicare Modernization Act" or "MMA") established requirements for a new Competitive Bidding Program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must

comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

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

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

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

DMEPOS CBP Round One Recompete

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

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

Note: If a beneficiary (who would have been entitled to obtain items from a grandfathered supplier) switches to a contract supplier, the contract supplier is eligible to receive additional rental payments as provided in 42 CFR 414.408. See **http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=165d5eb7abb8a86a0432249796c83b61&rgn=div5&view=text&node=42:3.0.1.1.1&idno=42** on the Internet.

Grandfathering Provision

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

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

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

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

Scenarios

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

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

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

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

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

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

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

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

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

Additional Information

You can find out more about DMEPOS Competitive Bidding Program at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html** on the CMS website. The official instruction, CR 8270 issued to your DME MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1219CP.pdf** on the CMS website. 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.

New Healthcare Common Procedure Coding System (HCPCS) Codes for Customized Durable Medical Equipment (MM8158) (GEN)

MLN Matters® Number: MM8158 Revised
Related CR Release Date: May 21, 2013
Related CR Transmittal #: R1239OTN

Related Change Request (CR) #: CR 8158
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: *This article was revised on May 23, 2013, to reflect the revised CR8158 issued on May 21. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.*

Provider Types Affected

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

Contractors (A MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

Impact to You

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

What You Need to Know

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

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

What You Need to Do

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

Background

Customized DME Items

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

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

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

Payment for Customized DME Items

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

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

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

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

Additional Information

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

Phase III Electronic Remittance Advice (ERA) Enrollment Operating Rules (MM8223) (GEN)

MLN Matters® Number: MM8223 Revised
Related CR Release Date: May 10, 2013
Related CR Transmittal #: R1235OTN
Related Change Request (CR) #: 8223
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Note: *This article was revised on May 10, 2013, to reflect a revised CR8223 issued on May 10. In the article, the CR release date, transmittal number, and the Internet address for accessing the CR were revised. All other information remains the same.*

Provider Types Affected

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

What You Need to Know

Impact to You

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

What You Need to Know

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

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

What You Need to Do

Make sure that your billing staffs are aware of these updates to the ERA Enrollment Operating Rules.

Background

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

What You Need to Know about the ERA Enrollment Form

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

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

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

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

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

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

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

Additional Information

The official instruction, CR 8223, issued to your FI, carrier and A/B MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1235OTN.pdf** on the CMS website. If you have any questions, please contact your FI, carrier or A/B 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.

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2013 Update (MM8286) (DRU)

MLN Matters® Number: MM8286
Related CR Release Date: May 2, 2013
Related CR Transmittal #: R2695CP

Related Change Request (CR) #: CR 8286
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

Provider Action Needed

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

Key Points of CR8286

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

- J3487: Injection, Zoledronic Acid (Zometa), 1mg.
- J3488: Injection, Zoledronic Acid (Reclast), 1mg.
- J9002: Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10mg.

Effective for claims with dates of service on or after July 1, 2013, the following HCPCS codes will be payable for Medicare:

- Q2033: Influenza Vaccine, Recombinant Hemagglutinin Antigens, For Intramuscular Use (Flublok).
- Q2050: Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10mg.
- Q2051: Injection, Zoledronic Acid, not otherwise specified, 1mg.

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

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

Additional Information

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

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2013 (MM8232) (GEN)

MLN Matters® Number: MM8232
Related CR Release Date: April 5, 2013
Related CR Transmittal #: R2682CP

Related Change Request (CR) #: CR 8232
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

What You Need to Know

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

Background

Section 302 of the *Medicare Modernization Act of 2003* (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS awards payment amounts resulting from the competition to replace the

Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards.

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

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

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

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

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

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

Updates to the ZIP Code Files:

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

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

Additional Information

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

If you have any questions, please contact your RHHI, or 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.

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

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

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2013 (MM8316) (GEN)

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

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

Additional Information

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

If you have any questions, please contact your RHHI or 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.

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

Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM8246) (GEN)

MLN Matters® Number: MM8246
Related CR Release Date: March 15, 2013
Related CR Transmittal #: R2672CP

Related Change Request (CR) #: CR 8246
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8246 which provides the annual update to Home Health (HH) consolidated billing effective July 1, 2013. CR 8246 adds the following HCPCS codes to the HH consolidated billing therapy code list: **G0456** (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters) and **G0457** (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm).

Background

The *Social Security Act* (Section 1842(b)(6); see **http://www.ssa.gov/OP_Home/ssact/title18/1842.htm** on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see **http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=e49c86165ce00a5c3e044053adf4c2d0&rgn=div5&view=text&node=42:2.0.1.2.9&idno=42** on the Internet) and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20; see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf** on the Centers for Medicare & Medicaid Services (CMS) website).

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

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

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

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods.
The following are not subject to HH consolidated billing:

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

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

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

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

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

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

Additional Information

The official instruction, CR8246 issued to your DME MACs, FIs, RHHIs, and A/B MACs regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2672CP.pdf** on the CMS website. If you have any questions, please contact your DME MAC, FI, RHHI or A/B 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.

Questionable Billing By Suppliers of Lower Limb Prostheses (SE1213) (O&P)

MLN Matters® Number: SE1213 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 April 11, 2013, to remove a note box that had appeared on page 5. All other information is the same.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What You Need to Know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare Administrative Contractors (MACs), three Zone Program Integrity Contractors (ZPICs), and two DME Program Safeguard Contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings:

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.

2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.

3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.

4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
    - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
    - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
    - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations

The OIG made six recommendations based upon their findings. The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. The recommendations and CMS actions are as follows:

OIG Recommendation 1: Implement additional claims processing edits to prevent inappropriate payments. CMS should instruct the four DME MACs to implement claims processing edits based on all of the local coverage determination requirements.

CMS Response: CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

OIG Recommendation 2: Strengthen monitoring of billing for lower limb prostheses. CMS should instruct the DME MACs, ZPICs, and DME PSCs to monitor billing for lower limb prostheses using the measures discussed in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional reviews of suppliers that exceed the thresholds.

CMS Response: CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

OIG Recommendation 3: Implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses. We recommend that CMS implement requirements that the referring physician document that a face-to-face encounter occurred. This would help ensure that lower limb prostheses provided to beneficiaries are medically necessary.

CMS Response: CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

OIG Recommendation 4: Revise the requirements in the local coverage determination. CMS should work with the DME MACs to clarify several aspects of the local coverage determination. First, CMS should clarify the definitions of beneficiaries' functional levels. Second, CMS should revise the local coverage determination or take other steps to require that licensed/certified medical professionals, such as physical therapists, evaluate beneficiaries to determine their potential functional levels. Finally, CMS should consider denying as medically unnecessary certain combinations of prostheses.

CMS Response: CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

OIG Recommendation 5: Enhance screening for currently enrolled suppliers of lower limb prostheses. Federal regulations place new DMEPOS suppliers at the high-risk level and currently enrolled DMEPOS suppliers at the moderate-risk level. CMS should consider placing current suppliers of lower limb prostheses at the high-risk level, thus subjecting them to the more rigorous screening procedures.

CMS Response: CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

OIG Recommendation 6: Take appropriate action on suppliers with questionable billing. In a separate memorandum, we will refer the suppliers that we identified to CMS for appropriate action.

CMS Response: CMS concurred and stated it would share the information with the DME MACs and the Recovery Audit Contractors. Recovery Audit Contractors review Medicare claims on a post payment basis to identify inappropriate payments.

The following section reviews Medicare policy for coverage of lower limb prostheses.

Key Points

Medicare Requirements for Lower Limb Prostheses

Provisions of the *Social Security Act* (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers and the referring physicians must take into account the beneficiary's history, current overall medical condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain items that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening - limited, moderate, and high - based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

Note: *You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review MLN Matters® Article SE1201 at* **http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf** *for important reminders on the requirements for Ordering and Referring Physicians.*

Additional Information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The entire OIG report titled "*Questionable Billing By Suppliers of Lower Limb Prostheses*" is available at **http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf** on the OIG website.

Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update (MM8281) (GEN)

MLN Matters® Number: MM8281 Revised
Related CR Release Date: April 12, 2013
Related CR Transmittal #: R2686CP
Related Change Request (CR) #: CR 8281
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: *This article was revised on April 30, 2013, to revise the news flash (above) to show the Phase 2 edits are delayed. 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), Regional Home Health Intermediaries (RHHIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and A/B MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8281, which instructs Medicare contractors to make programming changes to incorporate updates to the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs the Fiscal Intermediary Standard System (FISS) and the VIPs Medicare System (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Please make sure that your billing staffs are aware of these changes.

Background

The *Health Insurance Portability and Accountability Act (HIPAA) of 1996*, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARC and appropriate RARC that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

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

CR8281 lists only the changes that have been approved since the last code update CR (CR8154, Transmittal 2618, issued on December 21, 2012, available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8154.pdf**), and does not provide a complete list of codes for these two code sets.

Note: *In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.*

Changes in CARC List Since CR8154

These are the changes in the CARC database since the last code update CR8154. The full CARC list must be downloaded from the WPC website, available at **http://wpc-edi.com/Reference** on the Internet.

New Codes - CARC: None

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. *Start: 01/01/1995 | Last Modified: 01/20/2013*	11/1/2013
18	Exact duplicate claim/service (Use only with Group Code OA) *Start: 01/01/1995 | Last Modified: 01/20/2013*	1/20/2013
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. *Start: 01/01/1995 | Last Modified: 01/20/2013*	11/1/2013
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA) *Start: 02/28/1997 | Last Modified: 01/20/2013*	1/20/2013

Deactivated Codes - CARC:

Code	Current Narrative	Effective Date
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) *Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 11/01/2013*	11/1/2013

Changes in RARC List Since CR8154

These are the changes in the RARC database since the last code update CR8154. The full RARC list must be downloaded from the WPC website, available at **http://wpc-edi.com/Reference** on the Internet.

New - RARC:

Code	Current Narrative	Effective Date
N567	Not covered when considered preventative. *Start: 03/01/2013*	3/1/2013
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative. *Start: 03/01/2013*	3/1/2013
N569	Not covered when performed for the reported diagnosis. *Start: 03/01/2013*	3/1/2013
N570	Missing/incomplete/invalid credentialing data *Start: 03/01/2013*	3/1/2013

Code	Current Narrative	Effective Date
N571	Alert: Payment will be issued quarterly by another payer/contractor. *Start: 03/01/2013*	3/1/2013
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted. *Start: 03/01/2013*	3/1/2013
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor. *Start: 03/01/2013*	3/1/2013

Modified Codes - RARC:

Code	Current Narrative	Effective Date
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed. *Start: 11/01/2012 | Last Modified: 03/01/2013*	3/1/2013

Deactivated Codes - RARC: **NONE**

Additional Information

The official instruction, CR8281, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2686CP.pdf** on the CMS website. If you have any questions, please contact your FI, RHHI, carrier, DME MAC, or A/B 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.

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

MLN Matters® Number: MM8182 Revised
Related CR Release Date: May 9, 2013
Related CR Transmittal #: R1233OTN

Related Change Request (CR) #: CR 8182
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Note: *This article was revised on May 10, 2013, to reflect a revised CR8182 issued on May 9. In the article, the CR release date, transmittal number, and the Internet address for accessing the CR were revised. All other information remains the same.*

Provider Types Affected

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

What You Need To Know

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

Background

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

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

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

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

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

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

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

Business Scenarios

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

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

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

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

Scenario #2 - Additional Information Required - Missing/Invalid/Incomplete Data from Submitted Claim
This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.
Scenario #3 - Billed Service Not Covered by Health Plan
This scenario refers to situations in which the billed service is not covered by the health plan.
Scenario #4 - Benefit for Billed Service Not Separately Payable
This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

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

Additional Information

The official instruction, CR8182, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1233OTN.pdf** on the CMS website You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or 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.

Update to Chapter 15 of the Program Integrity Manual (PIM) (MM8222) (GEN)

MLN Matters® Number: MM8222
Related CR Release Date: April 26, 2013
Related CR Transmittal #: R461PI
Related Change Request (CR) #: CR 8222
Effective Date: May 28, 2013
Implementation Date: May 28, 2013

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8222, which makes several revisions to Chapter 15 of the Centers for Medicare & Medicaid Services (CMS) "*Medicare Program Integrity Manual*." The key clarification is as follows:

- Sections 15.25.1.2 and 15.25.2.2 (Reconsideration Requests) are revised as follows: Consistent with 42 CFR 498.24(a), the provider, the supplier, or the Medicare contractor may submit corrected, new, or previously omitted documentation or other facts in support of its reconsideration request of a provider enrollment denial or revocation at any time prior to the Hearing Officer's (HO's) decision. The HO must determine whether the denial or revocation is warranted based on all of the evidence presented. This includes:
  - The initial determination itself,
  - The findings on which the initial determination was based,
  - The evidence considered in making the initial determination, and
  - Any other written evidence submitted under 42 CFR 498.24(a), taking into account facts relating to the status of the provider or supplier subsequent to the initial determination.

Additional Information

The official instruction, CR8222 issued to your FI, RHHI, carrier, or A/B MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R461PI.pdf** on the CMS website. If you have any questions, please contact your FI, RHHI, carrier or A/B 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 a Rubber Stamp for Signature (MM8219) (GEN)

MLN Matters® Number: MM8219
Related CR Release Date: May 17, 2013
Related CR Transmittal #: R465PI

Related Change Request (CR) #: CR 8219
Effective Date: June 18, 2013
Implementation Date: June 18, 2013

Provider Types Affected

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

What You Need to Know

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

Additional Information

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

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.shtml**. This quarter the following notices have been posted:

- 2nd Quarter 2013 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File - Revised
- 2nd Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 2nd 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.

CMS e-News Links (GEN)

May

CMS e-News for Thursday, May 30, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-30-Enews.pdf

CMS e-News for Thursday, May 23, 2013
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-23-Enews.pdf

CMS e-News for Thursday, May 16, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-16-Enews.pdf

CMS e-News for Thursday, May 09, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-09-enews.pdf

CMS e-News for Thursday, May 02, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-02-Enews.pdf

April

CMS e-News for Thursday, April 25, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-25Enews.pdf

CMS e-News for Thursday, April 18, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-18Enews.pdf

CMS e-News for Thursday, April 11, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-11-Enews.pdf

CMS e-News for Thursday, April 4, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-04-04-Enews.pdf

March

CMS e-News for Thursday, March 28, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-28-enews.pdf

CMS e-News for Thursday, March 21, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-21-e-News.pdf

CMS e-News for Thursday, March 14, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-14-eNews.pdf

CMS e-News for Thursday, March 7, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-03-07-eNews.pdf

CMS News Flash (GEN)

REVISED products from the Medicare Learning Network® (MLN)

- "*CMS Website Wheel*," Educational Tool, ICN 006212, Hard Copy. **http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs**

- "*Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services*", Fact Sheet, ICN 904084, Downloadable **http://www.cms.gov/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf**

- "*Medicare Vision Services*," Fact Sheet, ICN 907165, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/VisionServices_FactSheet_ICN907165.pdf**

- "*Medicare Remit Easy Print Software*", Fact Sheet, ICN 006740, downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareRemit_0408.pdf**

- "*The DMEPOS Competitive Bidding Program Billing Procedures for Upgrades*," Fact Sheet, ICN 900924, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Mail_Order_Factsheet_ICN900924.pdf**

- "*The DMEPOS Competitive Bidding Program: Grandfathering Requirements for Non-Contract Suppliers*," Fact Sheet, ICN 900923, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Grandfathering_Factsheet_ICN900923.pdf**

- "*The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Traveling Beneficiary*," Fact Sheet, ICN 904484, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Travel_Bene_Factsheet_ICN904484.pdf**

- "*The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers*," Fact Sheet, ICN 903768, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PhysOther_FactSheet_ICN903768.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**

Providing the Annual Wellness Visit

The new publication titled "*Providing the Annual Wellness Visit*" is now available in downloadable format from the Medicare Learning Network® at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AnnualWellnessVisit-ICN907786.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. This brochure is designed to provide education on the Annual Wellness Visit, providing Personalized Prevention Plan Services, at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update their personalized prevention plan.

Flu Season Isn't Over

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 **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Flu_Products.pdf** and Resources and CMS Immunizations **http://www.cms.gov/immunizations** web pages for information on coverage and billing
- HealthMap Vaccine Finder (**http://flushot.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 (**http://www.cdc.gov/flu/freeresources/**) website offers a variety of provider resources for the 2012-2013 flu season.

Round 2 and National Mail-Order Competitions of the DMEPOS Competitive Bidding Program

On January 30, 2013, CMS announced the single payment amounts for the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. For additional information, see the Press Release (**http://www.cms.gov/apps/media/press/release.asp?Counter=4512**), a related Fact Sheet (**http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4513**), and other information on the CMS website (**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html**).

Delay Turning on Phase 2 Denial Edits

CMS has instructed its contractors to delay turning on Phase 2 denial edits on the following claims to check for a valid individual National Provider Identifier (NPI) and to deny the claim when this information is missing:

- Medicare Part B laboratory and imaging claims and Durable Medical Equipment, Orthotics, and Supplies (DMEPOS) claims that require an ordering or referring physician/non-physician provider; and
- Part A Home Health Agency (HHA) claims that require an attending physician provider.

CMS will advise you of the new implementation date in the near future. In the interim, informational messages will continue to be sent for those claims that would have been denied had the edits been in place. See MLN Matters® Article SE1305 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf**) for more information.

Has Medicare sent you a notice to revalidate your enrollment?

Has Medicare sent you a notice to revalidate your enrollment? If you are not sure, you can find lists of providers sent notices to revalidate their Medicare enrollment by scrolling to the "Downloads" section at **http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp** on the Centers for Medicare & Medicaid Services (CMS) website. That site currently contains links to lists of providers sent notices from September, 2011 through January, 2012. Information on revalidation letters sent in February will be posted in late March. For ease of reference, the lists are in order by National Provider Identifier and the date the notice was sent.

New Electronic Mailing List

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 Educational Products Electronic Mailing List

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!

Looking for the latest new and revised MLN Matters® articles?

Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf** and start receiving updates immediately!

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

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/medical_review/mr_index.shtml

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

---

Billing Reminder - Units of Service for Oral Anticancer Drugs (OACD) (DRU)

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

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

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

Coverage Reminder - Requirements for High Utilization of Glucose Monitor Strips and Lancets (SPE)

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

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

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

The specific policy requirements for supplies state:

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

Usual Utilization

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

High Utilization

- For a beneficiary who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a) - (c) below are met.
- For a beneficiary who is currently being treated with insulin injections, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a) - (c) below are met.
    a. Basic coverage criteria (1) - (2) listed above for all home glucose monitors and related accessories and supplies are met; and,
    b. The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary; and,
    c. If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

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

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

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

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

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

External Infusion Pumps LCD - Revised (SPE)

The External Infusion Pumps LCD refill requirements have been revised to 3-month interval to be consistent with the previously published instructions in the August 2012 article, "*Items Provided on a Recurring Basis and Request for Refill Requirements - Revised - August 2012*".

For complete information, review the entire LCD and/or related Policy Article.

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

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

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

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

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

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

F2F Scenarios

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

- The ordering physician has an initial in-person encounter with the beneficiary (#1 above) but does not complete the medical evaluation component (#2 above) of the F2F examination at this initial visit. At a subsequent visit with the ordering physician, the medical evaluation component is completed. In this situation, the date of the F2F examination is the date of the subsequent in-person encounter when the medical evaluation is completed.

- The ordering physician completes the decision component (#1 above) of the F2F examination at the initial in-person encounter with the beneficiary. The beneficiary is referred to another licensed clinical medical professional (LCMP) such as an Occupational Therapist (OT) or Physical Therapist (PT), who has experience and training in mobility evaluations, to perform all or a portion of the medical evaluation component (#2 above) of the F2F examination. The physician must indicate concurrence or any disagreement with the information in the written evaluation, sign and date the document. The F2F date listed on the 7-element order is the date the physician signed, dated and indicated concurrence or disagreement with the LCMP mobility evaluation.

- The ordering physician refers the beneficiary to an LCMP prior to the in-person encounter (#1 above) with the beneficiary. Once the physician has received and reviewed (stated concurrence, signed, and dated) the written report of the LCMP medical examination (#2 above), the physician must see the beneficiary and complete the decision component (#1 above). In this scenario, the date of the F2F examination reported on the 7-element order would be the date of the in-person encounter between the physician and beneficiary.

- The F2F examination is performed and completed during an inpatient hospital or nursing home stay, the date of the F2F examination reported on the 7-element order is either: 1) the date that both components 1 and 2 above are completed; or, 2) the date of discharge.

- The F2F examination has been completed, but the physician later identifies that there is information not properly documented in the medical record about the beneficiary which is necessary to support coverage criteria for a PMD. If the physician provides an amendment, correction or addenda to the F2F examination with information that arose from the previously performed F2F evaluation (both #1 & #2 above), the F2F examination date does not change on the 7-element order. The amendment, correction or addenda to the F2F evaluation should appear in the beneficiary's medical record.

- The F2F examination has been completed, but the physician later identifies that there is information that was not addressed during the F2F examination (both #1 & #2 above) which is necessary to support coverage criteria for a PMD. The physician must provide this new information in the medical record but since this was not a part of the original F2F, this does require a new in-person visit for the patient with the physician. This new F2F visit date becomes the F2F date on the 7-element order.

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

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

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

Suppliers are encouraged to review the *Program Integrity Manual* available on the Centers for Medicare & Medicaid Services Web site for additional information on amendments, corrections and delayed entries in medical documentation. This can be found in publication 100-08, chapter 3, section 3.3.2.5.
(**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf**)

Additional information on how to change a 7-element order can be found in an article titled, "*Changing a 7-Element-Order for a Power Mobility Device*"
(**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/091412_7eo.pdf**) available on the NHIC Web site. Suppliers can obtain additional information regarding medical necessity and documentation requirements for Power Mobility Devices in the Local Coverage Determination for Power Mobility Devices (L21271) and related policy article (A36239) (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**) which are also available on the NHIC Web site.

LCD and Policy Article Revisions Summary for March 07, 2013 (GEN)

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

Cervical Traction Devices

LCD

Revision Effective Date: 02/04/2011 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirements language to specify a "detailed written order"
Changed: Word "patient" to "beneficiary"
DOCUMENTATION REQUIREMENTS:
Added: Standard language (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference.*)

Policy Article

Revision Effective Date: 04/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: DME benefit category statement

Infrared Heating Pad Systems

LCD

Revision Effective Date: 07/01/2007 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Language clarifying NCD 270.6 as the reason for denial
Changed: Word "patient" to "beneficiary"

Policy Article

Revision Effective Date: 04/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: DME benefit category statement

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2013
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: L5859 coverage criteria
HCPCS CODES AND MODIFIERS:
Added: L5859
DOCUMENTATION REQUIREMENTS:
Added: L5859 to policy specific section

Policy Article

Revision Effective Date: 01/01/2013
CODING GUIDELINES:
Added: Preamble
Changed: Word "Patient" to "Beneficiary"

Manual Wheelchair Bases

LCD

Revision Effective Date: 03/01/2013 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Coverage criteria for K0005 and E1161 to conform with DMEPOS Quality Standards as a complex rehabilitation product
DOCUMENTATION REQUIREMENTS:
Revised: Proof of delivery section

Policy Article

Revision Effective Date: 03/01/2013
CODING GUIDELINES:
Revised: Weight clarification for coding
Revised: Degree of tilt requirement for E1161 and guidance for coding if less than 20 degrees of tilt.

Wheelchair Options/Accessories

LCD

Revision Effective Date: 01/01/2013
HCPCS CODES AND MODIFIERS:
Added: E2378
DOCUMENTATION REQUIREMENTS:
Revised: Proof of delivery section
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Changed: Narrative for same claim billing requirement of accessories and base

Policy Article

Revision Effective Dated: 01/01/2013
CODING GUIDELINES:
Added: Lap belt/safety belt to POV basic equipment package
Added: Guidelines for use of K0108 for heavy duty/bariatric
Added: Requirements regarding degrees of tilt and no separate payment if not meeting tilt requirement
Added: E2378 to bundling table

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

LCD and Policy Article Revisions Summary for March 14, 2013 (GEN)

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

Osteogenesis Stimulators

LCD

Revision Effective Date: 08/01/2009 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
Added: Refill requirements
DOCUMENTATION REQUIREMENTS:
Added: Standard Language (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference.*)
Revised: Prescription requirements

Policy Article

Revision Effective Date: 08/01/2009 (March 2013 Publication)
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES
Added: Preamble and benefit category statement

Patient Lifts

LCD

Revision Effective Date: 02/04/2011 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS:

Added: Standard Language (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference.*)
Revised: Prescription requirements

Policy Article

Revision Effective Date: 01/01/2010 (March 2013 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble and benefit category statement
Changed: "Patient" to "Beneficiary"

Pressure Reducing Support Surfaces - Group 2

LCD

Revision Effective Date: 01/01/2011 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Language explaining coverage criteria
Revised: Order requirements language to specify a "detailed written order"
Changed: Word "patient" to "beneficiary"

DOCUMENTATION REQUIREMENTS:

Added: Standard language (**Note:** *The effective date above is not applicable to these items. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference.*)
Removed: Requirement for the Statement of Certifying Physician (effective April 1, 2013)

Policy Article

Revision Effective Date: 04/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Changed: "patient" to "beneficiary"

CODING GUIDELINES:

Added: Statement for heavy duty and bariatric devices

Seat Lift Mechanisms

LCD

Revision Effective Date: 02/04/2011 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Order requirement language to specify a "written order prior to delivery"
Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS:

Added: Standard Language (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference.*)
Revised: Prescription requirements

Policy Article

Revision Effective date: 09/01/2009 (March 2013 Publication)
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble and benefit category statement
Changed: "Patient" to "Beneficiary"

Urological Supplies

LCD

Revision Effective Date: 02/04/2011 (March 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Order requirement language to specify a "detailed written order"
Added: Refill requirements
Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS:

Added: Standard Language (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference.*)
Revised: Prescription requirements

Policy Article

Revision Effective Date: 02/04/2011 (March 2013 Publication)
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES

Added: Benefit category statement
Changed: Word "Patient" to "Beneficiary"

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

LCD and Policy Article Revisions Summary for March 21, 2013 (GEN)

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

Hospital Beds and Accessories

LCD

Revision Effective Date: 02/04/2011 (March 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS:

(**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard Language

Policy Article

Revision Effective Date: 04/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES

Added: Preamble and benefit category statement

CODING GUIDELINES:

Changed: Word "Patient" to "Beneficiary"

Nebulizers

LCD

Revision Effective Date: 08/02/2011 (March 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirements language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS:

(**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard Language

Policy Article

Revision Effective Date: 04/01/2013
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:

Changed: Word "Patient" to "Beneficiary"

Ostomy Supplies

LCD

Revision Effective Date: 01/01/2013
HCPCS CODES AND MODIFIERS:
Added: A4435

Policy Article

Revision Effective Date: 01/01/2013
CODING GUIDELINES:
Added: A4435
Changed: Word "Patient" to "Beneficiary"

Pneumatic Compression Devices

LCD

Revision Effective Date: 01/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
HCPCS CODES AND MODIFIERS:
Added: E0670
DOCUMENTATION REQUIREMENTS:
(**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard Language
Changed: Word "Patient" to "Beneficiary"

Policy Article

Revision Effective Date: 04/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble and benefit category statement

Pressure Reducing Support Surfaces - Group 3

LCD

Revision Effective Date: 01/01/2011 (March 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Order requirements language to specify a "detailed written order prior to delivery"
Changed: Word "Patient" to "Beneficiary"
DOCUMENTATION REQUIREMENTS:
(**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard Language

Policy Article

Revision Effective Date: 04/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Written Order Prior To Delivery heading

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

LCD and Policy Article Revisions Summary for March 28, 2013 (GEN)

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

Enteral Nutrition

LCD

Revision Effective Date: 05/01/2013

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Changed: Word "Patient" to "Beneficiary"

Added: Verbiage regarding allowances under the Refill Requirement section.

DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Added: Standard Language

Added: 5th bullet under revised DIF requirements

Policy Article

Revision Effective Date: 05/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Changed: Word "Patient" to "Beneficiary"

Heating Pads and Heat lamps

LCD

Revision Effective Date: 04/01/2011 (March 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirements language to specify a "detailed written order"

DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Added: Standard Language

Changed: Word "Patient" to "Beneficiary"

Policy Article

Revision Effective Date: 05/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble and benefit category statement

Intrapulmonary Percussive Ventilation System

LCD

Revision Effective Date: 07/01/2007 (March 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirement language to specify a "detailed written order"

DOCUMENTATION REQUIREMENTS:

Changed: Word "Patient" to "Beneficiary"

Policy Article

Revision Effective Date: 05/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble and benefit category statement

Pressure Reducing Support Surfaces - Group 1

LCD

Revision Effective Date: 01/01/2011 (March 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Order requirements language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language
Removed: Requirement for the Statement of Certifying Physician (effective April 1, 2013)

Policy Article

Revision Effective Date: 04/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Changed: Word "Patient" to "Beneficiary"

Speech Generating Devices

LCD

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

Policy Article

Revision Effective Date: 04/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Changed: "DME" to "equipment"
CODING GUIDELINES:
Changed: Word "Patient" to "Beneficiary"

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

LCD and Policy Article Revisions Summary for April 4, 2013 (GEN)

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

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 05/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Changed: Word "Patient" to "Beneficiary"
DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language
Added: Standard therapy coverage criteria documentation

Policy Article

Revision Effective Date: 05/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Benefit category statement

Oral Anticancer Drugs

LCD

Revision Effective Date: 05/01/2013

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Changed: Word "Patient" to "Beneficiary"

Revised: Language for clarification and addition of CMS IOM references

DOCUMENTATION REQUIREMENTS:

Added: Dosage strength for J8999

(**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Added: Standard language

Policy Article

Revision Effective Date: 05/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Language for clarification and addition of CMS IOM references

Clarified: Billing information on units of service.

Added: Reference to the "NDC/HCPCS Crosswalk" on PDAC website

Orthopedic Footwear

LCD

Revision Effective Date: 10/01/2009 (April 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirements language to specify a "detailed written order"

Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Added: Standard language

Policy Article

Revision Effective Date: 04/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble

Added: DME benefit category statement

Updated: LCD title for Therapeutic Shoes for Persons with Diabetes

Respiratory Assist Devices

LCD

Revision Effective Date: 06/01/2013

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Revised: Order requirement language to specify a "detailed written order"

Changed: Word "Patient" to "Beneficiary"

Added: Refill requirements

Added: Replacement requirement clarification allowing use of pre-Medicare testing

DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Added: Standard language

Policy Article

Revision Effective Date: 06/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble and benefit category statement

Wheelchair Seating

LCD

Revision Effective Date: 05/01/2013

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Arthrogryposis, osteogenesis imperfecta, spinocerebellar disease and transverse myelitis to the list of covered conditions for skin protection seat cushions

Changed: Word "Patient" to "Beneficiary"

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: 323.82, 334.0-334.9, 728.3, 754.89, 756.51 to HCPCS codes set E2603, E2604, E2622, E2623

DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Added: Standard language

Policy Article

Revision Effective Date: 05/01/2013

CODING GUIDELINES:

Changed: Word "Patient" to "Beneficiary"

Added: Adjustable seat narrative incorporated from "Change to Wheelchair Cushion HCPCS Codes" originally published 12/14/2004 and reposted by the PDAC August, 2008

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

LCD and Policy Article Revisions Summary for April 11, 2013 (GEN)

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

Cold Therapy

LCD

Revision Effective Date: 01/01/2011 (April 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirements language to specify a "detailed written order"

Policy Article

Revision Effective Date: 05/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Benefit category statement

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 10/01/2011 (April 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Order requirement language to specify a "detailed written order"

Changed: Word "Patient" to "Beneficiary"

DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language

Refractive Lenses

LCD

Revision Effective Date: 05/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
HCPCS MODIFIERS:
Added: GY modifier
DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language
Added: GY modifier instruction

Policy Article

Revision Effective Date: 05/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Benefit category statement
Changed: Word "Patient" to "Beneficiary"

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 02/04/2011 (April 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language

Policy Article

Revision Effective Date: 05/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble and benefit category statement
CODING GUIDELINES:
Changed: Word "Patient" to "Beneficiary"

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

LCD and Policy Article Revisions Summary for April 18, 2013 (GEN)

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

Oral Antiemetic Drugs

LCD

Revision History Effective Date: 01/01/2012 (April 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Clarified: Detailed written order requirements
Added: Reference to CMS *Benefit Policy Manual*

Parenteral Nutrition

LCD

Revision Effective Date: 02/04/2011 (April 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
Added: Refill requirements
DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language

Policy Article

Revision Effective Date: 05/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Benefit category statement
Changed: Word "Patient" to "Beneficiary"

Power Mobility Devices

LCD

Revision Effective Date: 06/01/2011 (April 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Changed: Word "Patient" to "Beneficiary"
DOCUMENTATION REQUIREMENTS: (**Note:** *The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)
Added: Standard language

Policy Article

Revision Effective Date: 05/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble and benefit category statement
Changed: Word "Patient" to "Beneficiary"

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

LCD Revisions Summary for May 23, 2013 (GEN)

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

Respiratory Assist Devices (RAD)

LCD

Revision Effective Date: 06/01/2013 (May 2013 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: "or equal to" under Central Sleep Apnea (CSA) criterion 1

Removed: Refill paragraph which has been superseded by CMS *Program Integrity Manual*, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6 (Clerical correction)

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 02/04/2011 (May 2013 Publication)

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifier

DOCUMENTATION REQUIREMENTS:

Revised: KX, GA, GY or GZ modifier instruction

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

Manual Wheelchair Local Coverage Determination and Policy Article - Revised (MOB)

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

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

Oral Anti-Cancer Drugs - Coding and Billing Change (DRU)

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

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

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

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

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

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

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

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

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
- Proof of beneficiary testing blood glucose (if billing quantities above the LCD limits)
- 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 January 01, 2013 through March 31, 2013:

- The review involved DCRs of 9,378 claims.
- Of the 9,378 claims reviewed, 4,600 claims were denied resulting in a claim denial rate of 49%.
- Responses were not received for 22% of the issued Additional Documentation Requests (ADR).

Primary Reasons for Denial

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

- Request for refill incomplete (primarily) or missing; ex. quantity remaining missing
    - **Suppliers are strongly urged to review the article noted in the Educational References at the end of this article to address this #1 error.**

- Missing test logs/Proof of testing frequency (when billing quantities above the LCD limits)
- Proof of delivery missing or incomplete

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/Zone Program Integrity 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 website 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/dme/medical_review/mr_bulletin_current.shtml
- Coverage Reminder - Requirements for High Utilization of Glucose Monitor Strips and Lancets
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.shtml
- Glucose Monitor LCD (L11530) and Related Policy Article (A33614)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/suppmandownload.shtml
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.
- Dear Physician Letter for Glucose Monitor Supplies
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- DME MAC A Glucose Monitor Tutorial
  http://www.medicarenhic.com/dme/dme-eduonline.shtml
- DME MAC A Glucose Documentation Podcast
  http://www.medicarenhic.com/dme/dme-eduonline.shtml

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 January 01, 2013 through March 31, 2013:

- The review involved DCRs of 2,942 claims.
- Of the 2,942 claims reviewed, 1,593 claims were denied resulting in a claim denial rate of 54%.
- Responses were not received for 6.7% of the issued Additional Documentation Requests (ADR).

Primary Reasons for Denial

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

- 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/Zone Program Integrity 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 website 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/medical_review/mr_lcd_current.shtml
- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/suppmandownload.shtml
  - "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/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word oxygen)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: 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/medical_review/mr_bulletin_pca.shtml

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

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 66%. A summary of findings was published on the NHIC website on December 28, 2012. Based on this result, a widespread prepayment review was continued.

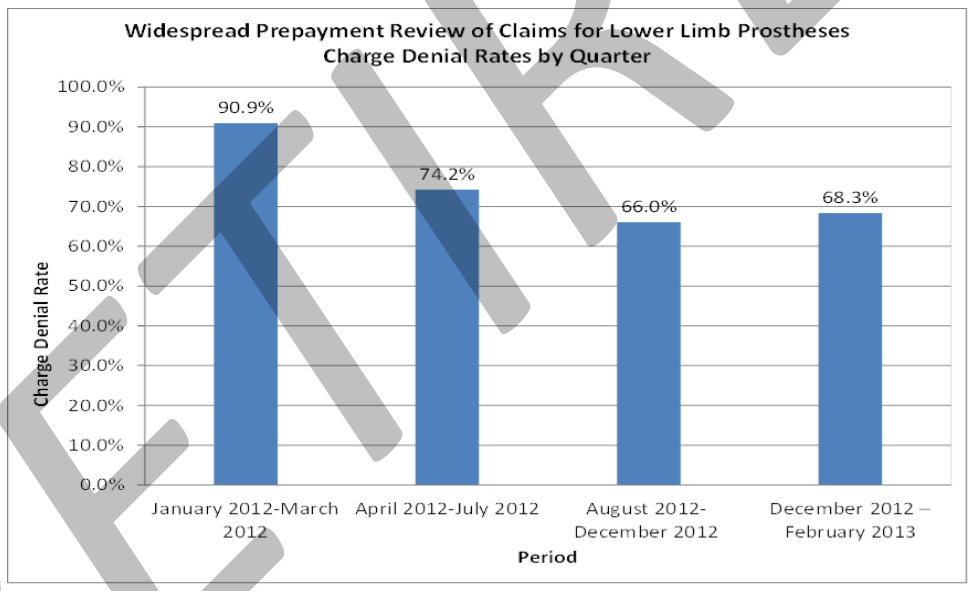
Current Review Results

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 141 claims submitted by 97 suppliers for claims processed December 2012 to February 2013. Responses to the Additional Documentation Request (ADR) were not received for 19 (13%) of the claims. For the remaining 122 claims, 28 claims were allowed and 94 were denied resulting in a claim denial rate of 77%. 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 68.3%.

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

- 30% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 4% 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

- 32% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 12% of the denied claims were missing the proof of delivery.

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.

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/medical_review/mr_lcd_current.shtml
- The DME MAC Jurisdiction A *Supplier Manual* (Chapter 10: includes information regarding documentation requirements)
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/phy_letters.shtml
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (Posted April 20, 2012; August 24, 2012 & December 28, 2012) **http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml**
- Results of Widespread Prepayment Probe for Lower Limb Prostheses (Posted November 30, 2011) **http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml**

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 June 2012 through August 31, 2012 and resulted in a Charge Denial Rate (CDR) of 76.1%.

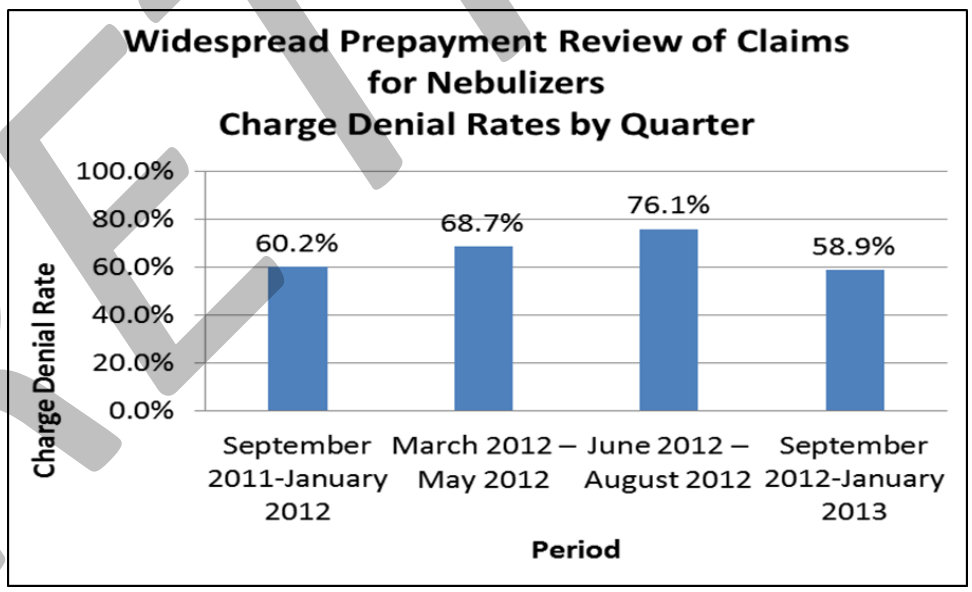
Current Review Results

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 September 2012 through January 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 443 claims submitted by 280 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 77 (17%) of the claims. For the remaining 366 claims, 120 claims were allowed (33%) and 246 were denied/partially denied resulting in a claim denial rate of 67%. 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 58.9%.

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

- 35% of the denied claims were missing any clinical information to support medical necessity.
  - No Medical records were submitted
- 19% of the denied claims had insufficient clinical documentation. The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer
    - Clinical documentation submitted did not list a payable diagnosis
    - Clinical documentation submitted had no mention of need for a nebulizer
  - Illegible copy of documentation submitted

Detailed Written Order Issues

- 4% of the denied claims were missing the detailed written order.
- 5% 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
  - 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% of the denied claims were missing proof of delivery.
- 21% 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.

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. No proof of delivery to support the item ordered was received by the beneficiary.

Example 2:

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 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. In instances where the nebulizer and supplies are delivered directly by the supplier, the proof of delivery must include a beneficiary signature and date of signature. The proof of delivery for this claim was missing the beneficiary signature and date of signature.

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.

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/medical_review/mr_lcd_current.shtml
- 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
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Nebulizers
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Monthly CERT Error examples (April 2011, May 2011, July 2011, January 2012, February 2012, May 2012, August 2012)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word “nebulizer”)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

Quiz yourself and your staff. Visit the DME MAC A Test Your Knowledge Quizzes today at:

http://www.medicarenhic.com/dme/dme_quiz_index.shtml

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 July 2012 through December 2012 and resulted in a 54.9% Charge Denial Rate (CDR).

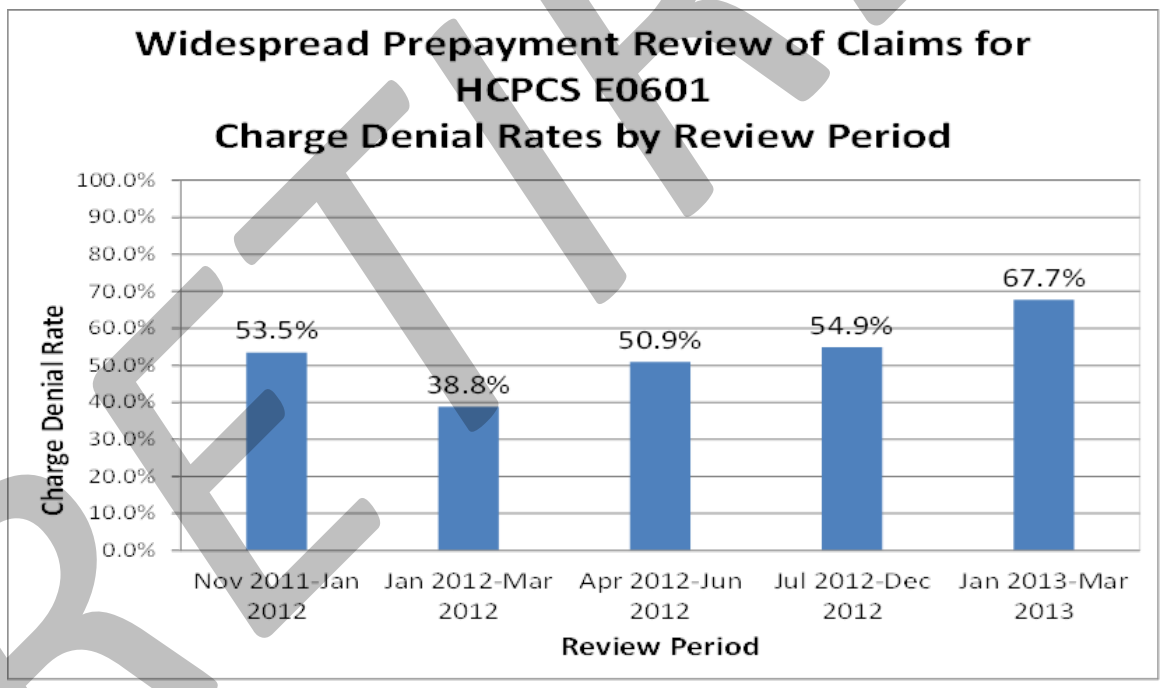
Current Review Results

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 January 2013 through March 2013. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 1,122 claims submitted by 365 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 178 (16%) of the claims. Of the 944 claims for which responses were received, 500 claims were allowed and 444 were denied/partially denied. This resulted in a claim denial rate of 47%. 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 67.7%.

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

- 26.1% 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 following the 5 year Reasonable Useful Lifetime (RUL) or when requesting coverage of a replacement PAP upon entering FFS Medicare.

- 34.5% 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.
- 5.1% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 1.5% of the denied claims had illegible Face-to-Face documents.

Detailed Written Order Issues

- 3.9% of the denied claims did not include the Detailed Written Order.
- 11.4% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 1.5% of the denied claims had a Detailed Written Order which was illegible.
- 0.5% of the denied claims had Detailed Written Orders written prior to the sleep study.

Sleep Study Documentation Issues

- 16% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 0.6% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 11.9% 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.
- 0.6% of the denied claims had Sleep Study documents which were not dated.

Training Documentation Issues

- 19.6% of the denied claims did not include evidence of training on the PAP device.
- 7.6% 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

- 5.8% of the denied claims were missing Proof of Delivery.
- 11.4% of the denied claims were missing billed items on the Proof of Delivery.

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 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: There was no detailed narrative in the Face-to-Face clinical evaluation that addresses evidence of current symptoms of a sleep disorder including but not limited to snoring, daytime sleepiness, observed apneas, choking/gasping during sleep, morning headaches, or a valid Epworth Sleepiness Scale.

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 Detailed Written Order submitted does not list all separately billed items.

Example 3:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written order, a Medicare approved Home Sleep Test, Proof of Delivery, and evidence of training on the PAP device.

Missing: There has been no evidence of beneficiary training prior to having the Home Sleep Test on how to properly apply a portable sleep monitoring device. This instruction must be provided by the entity conducting the Home Sleep Test and may not be performed by a DME supplier. Beneficiary training may be accomplished by Face-to-Face instruction, via video, or telephonic instruction and noted in the record.

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
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601) (Posted 02/28/2013, 11/30/2012, 08/24/2012, 04/20/2012, 12/22/2011, 08/19/2011, 3/4/2011, and 07/02/2010)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- 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/suppmandownload.shtml
- CERT Physician Letter - Positive Airway Pressure (PAP) Devices
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faq_results.asp?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) (GEN)

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 July 01, 2012 through September 30, 2012 and resulted in a 72.4% Charge Denial Rate (CDR).

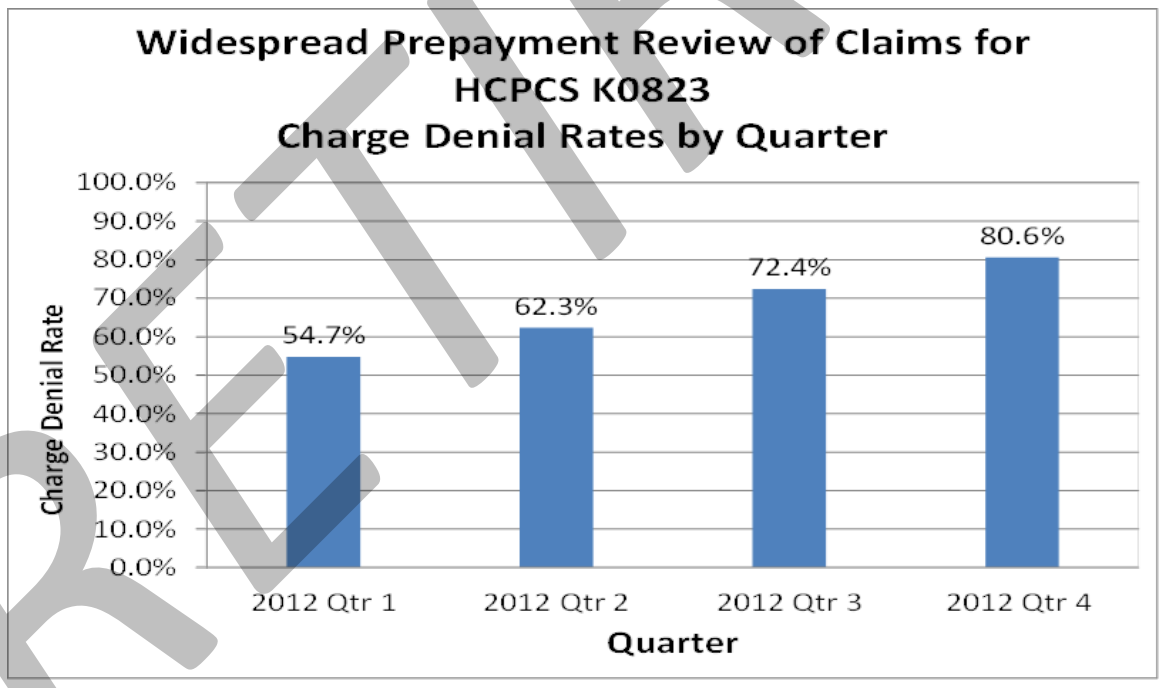
Current Review Results

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 October 01, 2012 through December 31, 2012. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 382 claims submitted by 152 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 103 (26%) of the ADR requests issued. Of the 279 claims for which responses were received, 44 of the claims were allowed and 235 of the claims were denied. This resulted in a claim denial rate of 84%. 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 80.6%.

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 Issues

- 43% of the denied claims had insufficient clinical documentation to support medical necessity. Examples:
  - The Face-to-Face Clinical Evaluation documentation provided did not address the history of the patient's present condition and did not address the patient's past medical history that is relevant to his/her mobility needs.

  - The Face-to-Face Clinical Evaluation documentation provided did not address the prior use or trials of other alternative mobility assistive devices.
  - The Face-to-Face Clinical Evaluation documentation provided did not include a comprehensive physical exam by the treating physician which, focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ability. The Face-to-Face Clinical Evaluation did not provide a clear picture of the patient's specific mobility limitations (i.e., upper and lower body strength, range of motion, coordination, pain levels, physical deformities and physical endurance).
  - The Face-to-Face Clinical Evaluation documentation was completed by the treating physician using a supplier generated form only. Per K0823 LCD L21271 - Even if the physician completes this type of form and puts it in his/her chart, this supplier generated form is not a substitute for the comprehensive medical record. The supplier generated Face-to-Face Clinical Evaluation form completed by the treating physician does not contain enough narrative information regarding the patient's specific mobility limitations to support the medical necessity for a power wheelchair.
  - The Face-to-Face Clinical Evaluation documentation provided did not clearly indicate that the reason for the visit was a mobility evaluation.
- 6% of the denied claims had a Face-to-Face date listed on the 7-Element Order that did not match the date of the Face-to-Face Clinical Evaluation.
- 11% of the denied claims did not have the treating physician's signature and/or the treating physician's signature date on the Face-to-Face Clinical Evaluation.
- 6% of the denied claims did not have the treating physician's signature in concurrence with the specialty exam.
- 13% 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. A date stamp or equivalent was not present.

7-Element Order Issues

- 1% of the denied claims did not include a 7-Element Order.
- 6% of the denied claims were incomplete, missing one or more of the required elements.
- 12% 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.
- 2% of the denied claims have the 7-Element Order and the Detailed Product Description on the same form.
- 1% of the denied claims have the 7-Element Order dated prior to the completion of the Face-to-Face Clinical Evaluation.

Detailed Product Description (DPD) Issues

- 9% of the denied claims did not include a Detailed Product Description.
- 2% of the denied claims had an incomplete Detailed Product Description.
- 14% of the denied claims had the Detailed Production Description dated prior to the physician's signature on the 7-Element Order.
- 8% of the denied claims did not include confirmation the supplier received a copy of Detailed Product Description prior to the delivery of the power wheelchair, as verified with a date stamp or equivalent from the supplier. A date stamp or equivalent was not present.
- 4% of the denied claims did not list a detailed description of the specific power wheelchair that the supplier had determine to be appropriate for the patient based on the physician's 7-Element Order.
- 3% of the denied claims did not have the treating physician's signature and/or the treating physician's signature date on the Detailed Product Description
- 1% of the denied claims had an illegible Detailed Product Description.

Proof of Delivery Issues

- 8% of the denied claims did not include Proof of Delivery.
- 4% of the denied claims had Proof of Delivery that did not match the claim date of service.
- 5% of the denied claims did not list the specific make & model of the power wheelchair that was delivered to the beneficiary.
- 3% of the denied claims did not include the beneficiary's signature and /or the beneficiary's signature date on the Proof of Delivery.

LCMP Specialty Exam issues

- 17% of the denied claims did not include a financial attestation statement stating the LCMP (Licensed/Certified Medical Professional) provider did not have a financial relationship with the supplier providing the wheelchair.

Home Assessment Issues

- 12% 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, (PWC).
- 1% of the denied claims had home assessments that were not signed and dated by either the supplier or the practitioner.

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, the Detailed Product Description, the Face-to-Face Clinical Evaluation, the Specialty Evaluation, the Financial Attestation, the Home Assessment, and the Proof of Delivery.
Missing: The 7-Element Order is missing the date of the Face-to-Face Clinical Evaluation. The Detailed Product Description was not dated by the treating physician.

Example 2

Received: Documentation provided in this claim included: the 7-Element Order, the Detailed Product Description, the Specialty Evaluation, and the Proof of Delivery.
Missing: Face-to-Face Clinical Evaluation by the treating physician. The documentation provided did not include a Home Assessment performed by the supplier representative, to verify the beneficiary can adequately maneuver the device in the home environment. Documentation does not include an attestation from the specialty evaluation provider stating they have no financial affiliation with the supplier.

Example 3

Received: Documentation provided in this claim included: the 7-Element Order, the Detailed Product Description, the Face-to-Face Clinical Evaluation, the Specialty Evaluation, the Financial Attestation, the Home Assessment, and the Proof of Delivery.
Missing: The Proof of Delivery documentation did not include the beneficiary's signature and the beneficiary's signature date.

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.

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/dmerc_cert_rec.shtml
- Power Mobility Devices (L21271) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Power Mobility Devices - 7-Element Order (published 11/05/09)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Power Mobility Devices Billing Reminder (published 01/11/08)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- 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 12/20/12, 9/28/12, 07/13/12, 04/20/12, 12/15/11, 08/26/11, 06/10/11, 03/11/11, and 11/05/10)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Frequently Asked Questions (search word PMD)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network; ICN 905063 September 2011)
  http://www.cms.gov/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

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

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 July 01, 2012 through September 30, 2012 and resulted in a 34.0 % Charge Denial Rate (CDR).

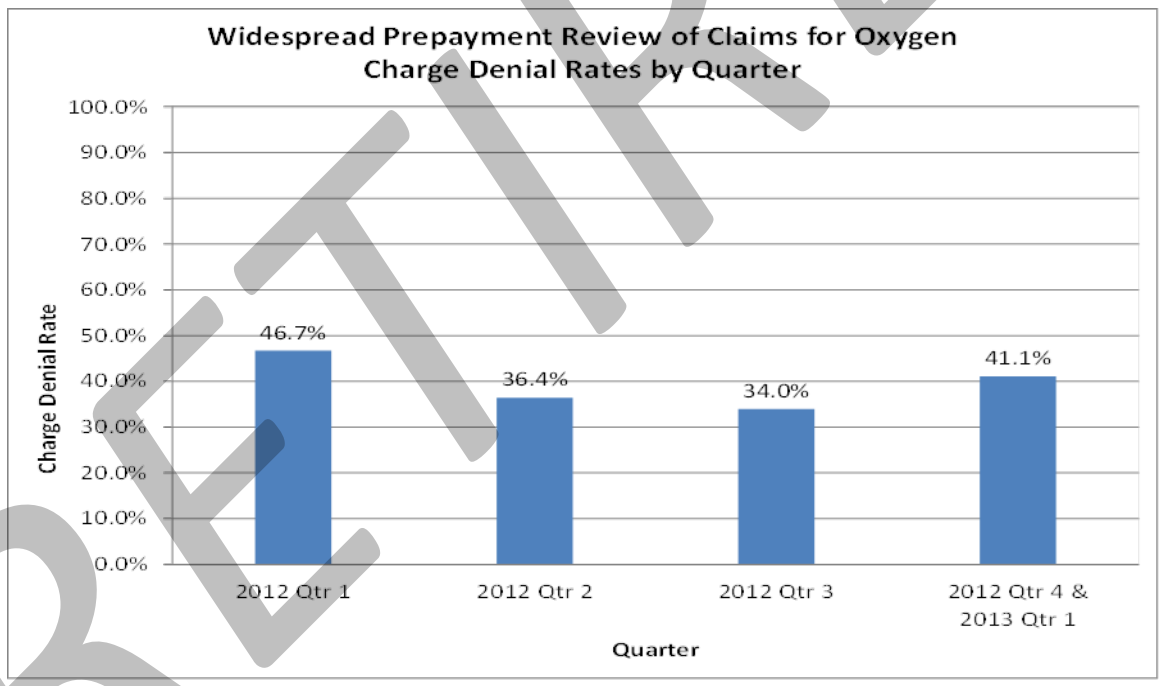
Current Review Results

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 October 01, 2012 through February 28, 2013.

The review involved prepayment complex medical review of 1,191 claims submitted by 347 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 130 (11%) of the claims. For the remaining 1,061 claims, 688 claims were allowed and 373 were denied resulting in a claim denial rate of 35%. 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 41.1%.

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 supplies LCD states:

Home oxygen is covered only when both the reasonable and necessary criteria are met. 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 per Local Coverage Determination (LCD) L11468 (89%)

Missing required physician visit:

- 50% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN

Missing qualifying blood gas study:

- 24% - No documentation to validate oxygen testing

Missing required Certificate of Medical Necessity:

- 5% - Missing an Initial CMN

Missing valid proof of delivery:

- 10% - Missing valid delivery ticket

Clinical Documentation Issues: Medical Necessity could not be established (11%)

Clinical documentation did not support criteria of LCD L11468 for the following reasons (5%):

- 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
- Frequency of use is specified to be PRN only
- Documentation illegible, unable to make determination
- Beneficiary admitted to hospice

Clinical documentation did not support criteria indicated on CMN for the following reasons (6%):

- 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
- Medical documentation received did not demonstrate qualifying oxygen saturation level. Written order only was received indicating an oxygen saturation level meeting Group I level criteria
- Saturation listed on CMN did not meet Group I criteria

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 03/19/12 billed: E1390, E0431

Documentation received: initial CMN dated 3/19/12; valid delivery ticket dated 3/19/12
Missing: Treating physician visit 30 days prior to initial CMN; authenticated qualifying oximetry results as documented under the conditions of the initial CMN of 87% at rest on 3/19/12; written physician order or verbal order

Example 2: DOS 10/15/12 code(s) billed: E1390, E0431

Documentation received: Treating physician progress notes within 30 days of initial CMN documenting qualifying diagnosis; outpatient preregistration form; laboratory results; written physician order dated 10/15/12; initial CMN dated 10/15/12; documentation of blood gas study including beneficiary's saturation exercising on room air on 10/15/12

Missing: Exercise oximetry report dated 10/15/12 including documentation of testing at rest without oxygen and testing during exercise with oxygen applied

Example 3: DOS 09/09/12 code(s) billed: E1390

Documentation received: Treating physician notes documenting qualifying diagnosis dated 04/17/12 and 12/12/12; verbal order; complete written order; results of overnight oximetry testing dated 08/28/12; delivery ticket dated 02/09/11
Missing: Initial CMN; valid delivery ticket dated 09/09/12

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/medical_review/mr_lcd_current.shtml
- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/suppmandownload.shtml
  - "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/dmerc_cert_rec.shtml
- CERT Physician Letter - Oxygen & Supplies
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word oxygen)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: February 08, 2013; October 12, 2012; June 29, 2012; March 02, 2012; November 04, 2011; August 26, 2011; November 5, 2010; and June 09, 2010).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Widespread Prepayment Probe for HCPCS Codes L0631 and L0637 (Lumbar-Sacral Orthoses) (SPE)

DME MAC A will be initiating a widespread prepayment probe of claims for the following HCPCS codes:

L0631 (LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT)

L0637 (LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT)

This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

Per the Local Coverage Determination (LCD) for Spinal Orthoses: TLSO and LSO (L11470):

HCPCS Code L0631and L0637 is covered when it is ordered for one of the following indications:

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

If a spinal orthosis is provided and the coverage criteria are not met, the item will be denied as not medically necessary.

Suppliers will be sent a documentation request for information listed below. The requested documentation must be returned within 45 days from the date of the letter to avoid claim denials.

Documentation should include the following items:

1. Physician order for the item. Include both the dispensing order (if applicable) and the detailed written order which include the following elements:
    - Description of the item
    - Beneficiary's name
    - Prescribing Physician's name
    - Date of the order and the start date, if the start date is different from the date of the order
    - Physician signature (if a written order) or supplier signature (if verbal order)
2. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item(s) are met.
3. Proof of delivery with name, address and signature of the beneficiary or designee; the item(s) provided; date of delivery; and supplier identification.
4. Invoice(s) for the item(s) provided including manufacturer name and model number.
5. Any other pertinent information that would justify payment for the item(s) provided.
6. Advanced Beneficiary Notice (ABN) if one was obtained, this must be submitted with the above requested documentation.

To avoid unnecessary denials for missing or incomplete information, please ensure when submitting documentation requests that all requested information is included with your file and respond in a timely manner.

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy Article. Suppliers can review the LCD for Spinal Orthoses: TLSO and LSO (L11470) and the related Policy Article (A23663) on the NHIC Web site at: **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

Join DME MAC A for Our Next Quarterly Ask-the-Contractor Teleconference (ACT) and Webinar (GEN)

Topics: Competitive Bidding Program Updates and FAQs / Open Q&A
Date: Tuesday, June 18, 2013
Time: 10:30 AM EDT - 12:00 PM EDT

Call Details

NHIC, Corp. DME MAC A will be hosting an Ask-the-Contractor Teleconference (ACT) and webinar. During this call, representatives from the DME MAC Provider Outreach & Education Team and the DMEPOS Competitive Bidding Implementation Contractor (CBIC) will give a presentation regarding recent updates and frequently asked questions on the Competitive Bidding program followed by an operator assisted question and answer period. *There is limited space available so please limit the number of lines used by your office. The call will begin promptly at 10:30AM EDT and last for one and a half hours.

The teleconference forum promotes an opportunity to share information, answer questions, and identify problems in a timely way. Participants learn from each other's questions and receive useful clarifications regarding the different rules and instructions associated with Fee-for-Service Medicare coverage, coding, and payment. All DMEPOS supplier types are encouraged to participate.

Registration

To participate, **webinar registration is required**. After your registration is complete, you will receive a confirmation email with instructions on how to join the webinar and teleconference. **Please retain your email confirmation** because you will not be able to access the ACT webinar without it.

Additional ACT call details are available at **www.medicarenhic.com/dme/dme_act.shtml#upcoming**

System Requirements

PC-based Attendees:	Required: Windows® 7, Vista, XP or 2003 Server
Macintosh®-based Attendees:	Required: Mac OS® X 10.4.11 (Tiger®) or newer

---

Billing Instructions for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Submitted with a Not Otherwise Classified (NOC) HCPCS (GEN)

DME MAC A is revising our billing instructions for DMEPOS submitted under Not Otherwise Classified (NOC) Healthcare Common Procedure Coding System (HCPCS) codes in order to accurately identify and price the billed products. Effective immediately, suppliers must include the following information in the NTE 2400 Field of Electronic Claims or Item 19 of paper claims when submitting a claim for a NOC code:

- Product Name
- Make/Model of Item
- Manufacturer's Suggested Retail Price (MSRP)

The NTE 2400 Field of an electronic claim is limited to 80 characters; therefore suppliers are encouraged to use our list of suggested abbreviations (**http://www.medicarenhic.com/dme/edi/sugg_abbre.pdf**) to condense all of the required information into this field.

Effective May 01, 2013, claims submitted to DME MAC A without any of the required elements will be rejected with American National Standards Institute (ANSI) code CO-16 with a reason code N350 which states, "Missing, incomplete, invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure." Appeal rights are not afforded and in order to correct these claim rejections suppliers must correct the claim and provide all of the required additional information needed for adjudication and resubmit.

Separate instructions are available for drugs submitted under NOC codes. Refer to the specific Local Coverage Determination (i.e. Oral Anti-Cancer Drugs, Immunosuppressive Drugs, etc.) for instructions regarding the submission of a drug under a NOC HCPCS code. In addition, some NOC HCPCS codes have additional policy specific narrative requirements. Suppliers are strongly encouraged to review the policy requirements for billing a NOC code in addition to these general requirements. A list of all Local Coverage Determinations is available on the DME MAC A Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

Note: This instruction provides a revision to the narrative requirements for processing NOC HCPCS codes by DME MAC A. In addition to including the Product Name and Make/Model of the Item, suppliers must now also include Manufacturer's Suggested Retail Price (MSRP). This change does not eliminate the requirement to include a brief narrative description of the item in the SV101-7 segment of electronic claims. If a claim is submitted without a brief narrative description of the item in the SV101-7 segment of electronic claims, it will not pass the front-end edits and will be rejected by CEDI.

Items Requiring Coding Verification Reviews by the PDAC (PDAC Article) (GEN)

The original version of this article can be found on the PDAC web site at:
https://www.dmepdac.com/resources/advisory_articles.html

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

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

CODE	LOCAL COVERAGE DETERMINATION	EFFECTIVE DATE
ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS		
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	4/1/2012
ENTERAL NUTRITION		
B4149	ENTERAL FORMULA, MANUFACTURED BLENDERIZED NATURAL FOODS WITH INTACT NUTRIENTS, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4153	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, HYDROLYZED PROTEINS (AMINO ACIDS AND PEPTIDE CHAIN), INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05

ENTERAL NUTRITION		
B4154	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS, EXCLUDES INHERITED DISEASE OF METABOLISM, INCLUDES ALTERED COMPOSITION OF PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND/OR MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4155	ENTERAL FORMULA, NUTRITIONALLY INCOMPLETE/MODULAR NUTRIENTS, INCLUDES SPECIFIC NUTRIENTS, CARBOHYDRATES (E.G. GLUCOSE POLYMERS), PROTEINS/AMINO ACIDS (E.G. GLUTAMINE, ARGININE), FAT (E.G. MEDIUM CHAIN TRIGLYCERIDES) OR COMBINATION, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4157	ENTERAL FORMULA, NUTRITIONALLY COMPLETE, FOR SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4161	ENTERAL FORMULA, FOR PEDIATRICS, HYDROLYZED/AMINO ACIDS AND PEPTIDE CHAIN PROTEINS, INCLUDES FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05
B4162	ENTERAL FORMULA, FOR PEDIATRICS, SPECIAL METABOLIC NEEDS FOR INHERITED DISEASE OF METABOLISM, INCLUDES PROTEINS, FATS, CARBOHYDRATES, VITAMINS AND MINERALS, MAY INCLUDE FIBER, ADMINISTERED THROUGH AN ENTERAL FEEDING TUBE, 100 CALORIES = 1 UNIT	4/1/05

KNEE ORTHOTICS		
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/08

MANUAL WHEELCHAIR BASES		
K0009	OTHER MANUAL WHEELCHAIR/BASE	6/1/13

NEGATIVE PRESSURE WWOUND THERAPY PUMPS		
E2402	NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE	1/1/06

NEBULIZERS		
E0574	ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER	4/1/11

ORAL APPLIANCES		
E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	9/1/11

OXYGEN AND OXYGEN EQUIPMENT		
E1405	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY	1/1/06
E1406	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY	1/1/06

PATIENT LIFT		
E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENT ACCESSIBLE CONTROLS	1/1/09
E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES	1/1/09
E0640	PATIENT LIFT, FIXED SYSTEM, INCLUDES ALL COMPONENTS/ACCESSORIES	1/1/09
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	1/1/09
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS	1/1/09

PNUEMATIC COMPRESSION DEVICES		
E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL	1/1/06
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE	1/1/06
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE	1/1/06

POWER MOBILITY DEVICES		
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	11/15/06
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06

POWER MOBILITY DEVICES		
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT 601 POUNDS OR MORE	11/15/06
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	11/15/06
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06

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

POWER MOBILITY DEVICES		
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	11/15/06
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS	11/15/06
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	11/15/06
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	11/15/06
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	11/15/06
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	11/15/06
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	11/15/06

PRESSURE REDUCING SUPPORT SURFACES - GROUP 2		
E0371	NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	1/1/06
E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS	1/1/06

SPINAL ORTHOSES: TLSO and LSO		
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION	8/31/11
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTEVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0452	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, CUSTOM FABRICATED	7/1/10

SPINAL ORTHOSES: TLSO and LSO		
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0458	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0462	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0464	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, FOUR RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

SPINAL ORTHOSES: TLSO and LSO		
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0470	TLSO, TRIPLANAR CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO SCAPULA, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, ROTATIONAL STRENGTH PROVIDED BY SUBCLAVICULAR EXTENSIONS, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANVERSE PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0472	TLSO, TRIPLANAR CONTROL, HYPEREXTENSION, RIGID ANTERIOR AND LATERAL FRAME EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH WITH TWO ANTERIOR COMPONENTS (ONE PUBIC AND ONE STERNAL), POSTERIOR AND LATERAL PADS WITH STRAPS AND CLOSURES, LIMITS SPINAL FLEXION, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0480	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0482	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10

SPINAL ORTHOSES: TLSO and LSO		
L0484	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITHOUT INTERFACE LINER, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0486	TLSO, TRIPLANAR CONTROL, TWO PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, LATERAL STRENGTH IS ENHANCED BY OVERLAPPING PLASTIC, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES A CARVED PLASTER OR CAD-CAM MODEL, CUSTOM FABRICATED	7/1/10
L0488	TLSO, TRIPLANAR CONTROL, ONE PIECE RIGID PLASTIC SHELL WITH INTERFACE LINER, MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO SCAPULAR SPINE, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH, ANTERIOR OR POSTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0490	TLSO, SAGITTAL-CORONAL CONTROL, ONE PIECE RIGID PLASTIC SHELL, WITH OVERLAPPING REINFORCED ANTERIOR, WITH MULTIPLE STRAPS AND CLOSURES, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION AND TERMINATES AT OR BEFORE THE T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XIPHOID, ANTERIOR OPENING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL AND CORONAL PLANES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0491	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0492	TLSO, SAGITTAL-CORONAL CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, THREE RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE XIPHOID, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL AND CORONAL PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10

SPINAL ORTHOSES: TLSO and LSO		
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0629	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0632	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10

SPINAL ORTHOSES: TLSO and LSO		
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0634	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0635	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANEL(S), LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0636	LUMBAR SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, LUMBAR FLEXION, RIGID POSTERIOR FRAME/PANELS, LATERAL ARTICULATING DESIGN TO FLEX THE LUMBAR SPINE, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, ANTERIOR PANEL, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0638	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10

SPINAL ORTHOSES: TLSO and LSO		
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	7/1/10
L0640	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED	7/1/10

SURGICAL DRESSINGS		
A6021	COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH	6/1/13
A6022	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN. , EACH	6/1/13
A6023	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 48 SQ. IN. , EACH	6/1/13
A6024	COLLAGEN DRESSING WOUND FILLER, STERILE, PER 6 INCHES	6/1/13
A6545	GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH	1/1/09

THERAPEUTIC SHOES FOR PERSONS WITH DIABETES		
A5512	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH	1/1/06
A5513	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH	1/1/06

WALKERS		
E0147	WALKER, HEAVY DUTY, MULTIPLE BRAKING SYSTEM, VARIABLE WHEEL RESISTANCE	1/1/06

WHEELCHAIR SEATING		
E2601	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2602	GENERAL USE WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04
E2603	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH LESS THAN 22 INCHES, ANY DEPTH	7/1/04
E2604	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, WIDTH 22 INCHES OR GREATER, ANY DEPTH	7/1/04

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

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

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

K0009 Manual Wheelchair - Coding Verification Review Requirement - Update (PDAC Article) (MOB)

The original version of this article can be found on the PDAC web site at:
https://www.dmepdac.com/resources/advisory_articles.html

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

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

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

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

First 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 January through March 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	119,158	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	24,099	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	17,338	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	14,237	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.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.380.2400.DTP03.080 Invalid Information within the Future date and Date(s) of service	12,362	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	11,251	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	9,287	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	9,185	Description must be present when Procedure Code requires a description/additional information.
X222.295.2320.SBR09.020 This Claim is rejected for Invalid Information within the Other Carrier Claim filing indicator is missing or invalid	7,215	Claim Filing Indicator Code must not = "MA" or "MB". Non-Medicare insurances will need to choose a valid code for the type of insurance being included in the claim file. "MA" and "MB" are not valid for Non-Medicare insurances.
X222.157.2300.CLM02.090 This Claim is rejected for Invalid Information on an MSP claim	7,158	The total claim level and line level adjustment amounts plus the primary paid amount must equal the total for all submitted charges.

First 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 first 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 January through March 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.	31,487
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.	14,113
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.	13,860
OA109, N104 - This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	11,778
CO 16 N51 - Electronic interchange agreement not on file for provider/submitter.	**Item 33** - The PTAN/NSC on file is not eligible to submit electronic claims.	3,012

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
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.	2,323
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).	1,799
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.	1,518
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.	1,318
CO 16 N286 - Missing / incomplete / invalid referring provider primary identifier.	**Item 17A** - Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	1,257

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 tables and share it with your colleagues.

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/dme_publications.shtml**. 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 March of 2013 chapters 3, 8, and 10 of the *DME MAC A Supplier Manual* were updated. In April 2013 chapter 6was updated. 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 (GEN)

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!

Join the NHIC, Corp. DME MAC A ListServe!

Visit **http://www.medicarenhic.com/dme/listserve.html** today!

For Your Notes

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.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

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**

DME MAC Jurisdiction A Resource

INFORMATION for DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI & VT

June 2013
Number 28

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
Hingham, MA 02043