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

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General Information

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:
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2013 DME MAC Jurisdiction A In-Person Seminars

Building Your Medicare Knowledge to New Heights

The Provider Outreach & Education (POE) Team is excited to be hosting eight educational events offering a dynamic range of topics. The theme for these sessions is "*Building Your Medicare Knowledge to New Heights*". Attendees will learn everything from the basics, to detailed documentation requirements, to recent Medicare changes during this one day learning experience. For more information on these upcoming events visit:

http://www.medicarenhic.com/dme/seminar/Seminar_General_Information.shtml

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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.

2013 Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List (MM8164) (GEN)

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

Provider Types Affected

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

Provider Action Needed

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

Additional Information

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

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM8043) (GEN)

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

Provider Types Affected

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

Provider Action Needed

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

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

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

Key Points

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

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

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

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

Additional Information

The official instruction, CR 8043, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2527CP.pdf** on the CMS website. More information on HH consolidated billing is in the "*Medicare Claims Processing Manual*," Chapter 10, Section 20, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf** on the CMS website. 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.

April 2013 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8161) (DRU)

MLN Matters® Number: MM8161
Related CR Release Date: December 28, 2012
Related CR Transmittal #: R2624CP

Related Change Request (CR) #: CR 8161
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected

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

What You Need to Know

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

Change Request (CR) 8161, from which this article is taken, instructs Medicare Contractors to implement the April 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2013, October 2012, July 2012, and April 2012 files. Make sure that your billing staffs are aware of these changes.

Background

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

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

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

Additional Information

You can find the official instruction, CR 8161, issued to your FI, carrier, A/B MAC, DME MAC, and RHHI by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2624CP.pdf** on the CMS website. If you have any questions, please contact your FI, carrier, A/B MAC, DME MAC, or RHHI 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.

April Quarterly Update for 2013 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8204) (GEN)

MLN Matters® Number: MM8204
Related CR Release Date: February 22, 2013

Related CR Transmittal #: R2661CP

Related Change Request (CR) #: CR 8204
Effective Date: January 1, 2013 for fee schedule amounts for codes in effect on January 1, 2013; April 1, 2013 for all other changes
Implementation Date: April 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (MACs), carriers, 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) 8204 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 codes and to revise any fee schedule amounts for existing codes that were calculated in error. 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 CR8204

- The coverage indicators for Healthcare Common Procedure Coding System (HCPCS) codes L8680, L8682, L8683, L8684, L86885, L8686, L8687, and L8688 have changed from invalid for Medicare ("I") to special coverage instructions apply ("D"), effective January 1, 2013. This change to the coverage indicators for codes L8680 and L8682 through L8688 are noted in the 2013 HCPCS Correction file, posted at **http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html** on the CMS website.

- The CY 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 are in the following table. The fee schedule amounts for these codes were updated for 2013 by applying the 2013 0.8 percent update factor to the 2012 fee schedule amounts.

	JURIS	CATG	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
AL	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
AR	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
AZ	L	PO	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
CA	L	PO	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
CO	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
CT	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
DC	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
DE	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
FL	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
GA	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
IA	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
ID	L	PO	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
IL	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
IN	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
KS	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
KY	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
LA	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
MA	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
MD	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
ME	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
MI	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
MN	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
MO	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
MS	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
MT	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
NC	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
ND	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
NE	L	PO	$431.78	$5,603.95	$4,932.79	$790.76	$12,292.16	$7,843.39	$15,997.03	$10,207.38
NH	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
NJ	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
NM	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
NV	L	PO	$440.40	$5,715.74	$5,031.17	$732.55	$12,537.39	$7,999.88	$16,316.14	$10,411.02
NY	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
OH	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93

	JURIS	CATG	L8680	L8682	L8683	L8684	L8685	L8686	L8687	L8688
OK	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
OR	L	PO	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
PA	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
RI	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
SC	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
SD	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
TN	L	PO	$432.04	$5,607.35	$4,935.72	$648.16	$12,299.59	$7,848.15	$16,006.69	$10,213.57
TX	L	PO	$432.00	$5,606.82	$4,935.27	$726.11	$12,298.45	$7,847.38	$16,005.21	$10,212.60
UT	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
VA	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
VT	L	PO	$419.40	$5,443.44	$4,791.47	$633.34	$11,940.07	$7,618.70	$15,538.80	$9,915.01
WA	L	PO	$435.71	$5,654.72	$4,977.44	$736.69	$12,403.49	$7,914.43	$16,141.88	$10,299.82
WI	L	PO	$441.29	$5,727.21	$5,041.26	$791.05	$12,562.56	$8,015.93	$16,348.90	$10,431.93
WV	L	PO	$421.17	$5,466.07	$4,811.39	$738.58	$11,989.72	$7,650.40	$15,603.42	$9,956.24
WY	L	PO	$440.03	$5,710.88	$5,026.89	$743.25	$12,526.69	$7,993.03	$16,302.26	$10,402.12
AK	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
HI	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PR	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
VI	L	PO	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

- Take note that the 2013 fee schedule amounts for HCPCS codes L8680 and L8682 through L8688 will not appear on the 2013 DMEPOS fee schedule files. A separate public use file containing only the 2013 fee schedule amounts for codes L8680, and L8682 through L8688 is available for download on the CMS DMEPOS fee schedule website at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html** on the CMS website.

Diabetic Testing Supplies

- In accordance with Section 636(b) of the *American Taxpayer Relief Act of 2012* (ATRA), effective for claims with dates of service on or after April 1, 2013, the 2009 fee schedule covered item update for non-mail order diabetic supplies is revised from 5 percent to -9.5 percent. Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as listed with the HCPCS codes below. As part of this update, the fee schedule amounts for these codes have been revised to reflect the change in the 2009 covered item update.
    - 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, effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the ATRA, the fee schedule amounts for non-mail order diabetic supplies will be further 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 Social Security Act. The national competitive bidding program for mail order diabetic supplies is scheduled to take effect July 1, 2013. The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 is:

- Mail Order Item (KL HCPCS modifier) - Any item shipped or delivered to the beneficiary's home, regardless of the method of delivery.
- 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.

A change request instruction and data file will be released for the July Quarterly Update to the 2013 DMEPOS Fee Schedule File to incorporate the new national payment amounts, and these amounts will be updated each time the amounts established in accordance

with Section 1847 of the Act are updated. The single payment amount public use file for the national mail order competitive bidding program will be available at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** on the internet.

Additional Information

The official instruction, CR8204 issued to your carrier, DME/MAC, or A/B MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2661CP.pdf** on the CMS website. Current and past DMEPOS Fee schedules can be viewed at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html** on the CMS website. If you have any questions, please contact your 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.

Calendar Year (CY) 2013 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8133) (GEN)

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

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

Provider Types Affected

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

What You Need to Know

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

Background and Key Points of CR8133

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

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

Fee Schedule Files

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

Healthcare Common Procedure Coding System (HCPCS) Codes Added/Deleted

The following new codes are effective as of January 1, 2013:

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

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

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

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

Specific Coding and Pricing Issues

1. The fee schedule amounts for shoe modification codes A5503 through A5507 are adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2013, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 are weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2011. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2013.

2. Effective January 1, 2013, new code L8605 Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ML is being added to the HCPCS code set. This code falls under the claims processing jurisdiction of local carriers rather than the DME MACs. Fee schedule amounts for this code are added as part of this update.

CY2013 Fee Schedule Update Factor

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

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

2013 Update to Labor Payment Rates

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

STATE	K0739	L4205	L7520
AK	$26.92	$30.67	$36.08
AL	14.29	21.3	28.91
AR	14.29	21.3	28.91
AZ	17.67	21.28	35.57
CA	21.93	34.96	40.75
CO	14.29	21.3	28.91
CT	23.87	21.77	28.91
DC	14.29	21.28	28.91
DE	26.32	21.28	28.91
FL	14.29	21.3	28.91

STATE	K0739	L4205	L7520
NC	14.29	21.3	28.91
ND	17.81	30.61	36.08
NE	14.29	21.28	40.31
NH	15.34	21.28	28.91
NJ	19.28	21.28	28.91
NM	14.29	21.3	28.91
NV	22.77	21.28	39.41
NY	26.32	21.3	28.91
OH	14.29	21.28	28.91
OK	14.29	21.3	28.91

STATE	K0739	L4205	L7520
GA	14.29	21.3	28.91
HI	17.67	30.67	36.08
IA	14.29	21.28	34.61
ID	14.29	21.28	28.91
IL	14.29	21.28	28.91
IN	14.29	21.28	28.91
KS	14.29	21.28	36.08
KY	14.29	27.27	36.97
LA	14.29	21.3	28.91
MA	23.87	21.28	28.91
MD	14.29	21.28	28.91
ME	23.87	21.28	28.91
MI	14.29	21.28	28.91
MN	14.29	21.28	28.91
MO	14.29	21.28	28.91
MS	14.29	21.3	28.91
MT	14.29	21.28	36.08

STATE	K0739	L4205	L7520
OR	14.29	21.28	41.57
PA	15.34	21.91	28.91
PR	14.29	21.3	28.91
RI	17.03	21.93	28.91
SC	14.29	21.3	28.91
SD	15.97	21.28	38.65
TN	14.29	21.3	28.91
TX	14.29	21.3	28.91
UT	14.33	21.28	45.02
VA	14.29	21.28	28.91
VI	14.29	21.3	28.91
VT	15.34	21.28	28.91
WA	22.77	31.21	37.07
WI	14.29	21.28	28.91
WV	14.29	21.28	28.91
WY	19.92	28.38	40.31

2013 National Monthly Payment Amounts for Stationary Oxygen Equipment

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

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

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

2013 Maintenance and Servicing Payment for Certain Oxygen Equipment

CR8133 also updates the 2013 payment amount for maintenance and servicing for certain oxygen equipment.
You can read more about payment for claims for maintenance and servicing of oxygen equipment in MLN Matters® Articles, MM6792, which is at
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990, which is at
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

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

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

Additional Information

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

have any questions, please contact your FI, carrier, 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.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) National Competitive Bidding (NCB): Using the "KY" Modifier to Bill for Accessories for Non-CB wheelchair Base Units (MM8181) (MOB)

MLN Matters® Number: MM8181
Related CR Release Date: February 8, 2013
Related CR Transmittal #: R1184OTN

Related Change Request (CR) #: CR 8181
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) suppliers submitting claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for standard power wheelchair and manual wheelchair accessories furnished for use with non-competitively bid wheelchair base units to Medicare beneficiaries who permanently reside in a Round 2 (or subsequent Round) competitive bid area (CBA).

Provider Action Needed

This article is based on Change Request (CR) 8181 and alerts suppliers to the requirement to use the "KY" modifier when billing for competitively bid (Round 2 or subsequent Round) wheelchair accessories used with certain non-competitively bid wheelchair base units for beneficiaries residing in Round 2 (or subsequent Round) CBAs. The "KY" modifier is used with accessory codes that are used with complex rehabilitative power wheelchair bases that are not Round 2 (or subsequent Round) competitive bid items, but were bid in Round 1 of the DMEPOS Competitive Bidding Program.

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 (CBA), 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.

CMS is required by law to re-compete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except mail-order diabetic supplies expires on December 31, 2013.

Standard Power Wheelchairs and Manual Wheelchairs are included in the Round 2 Standard (Power and Manual) wheelchairs, scooters, and related accessories product category. Since some of the accessories included in this product category can also be used with non-competitively bid wheelchair base units, a supplier providing an accessory for a non-competitively bid wheelchair base unit to a beneficiary who permanently resides in a CBA will need to use the "KY" pricing modifier in order for the claim to process correctly.

Since MIPPA mandated a 9.5% fee schedule reduction for items included in Round 1 of the Competitive Bidding Program, the "KE" modifier was used to differentiate wheelchair accessory codes used with both competitive bid and non-competitive bid wheelchair base units.

The "KE" modifier identifies accessories used with a non-competitive bid base unit and for which payment is not subject to the fee schedule reduction.

See below for Round 2 accessory billing scenarios that are based on the types of wheelchair bases that the accessory is used with and the competitive bid status of the base unit.

Under Round 2

Chair Bases bid: Manual (K1, K2, K3, K4, K6, K7) and standard PMDs
Example: billing accessory code E0950

Accessory Code E0950 used with a:	Base Code Competitive Bid Status	Claim for a Beneficiary who Permanently Lives in a CBA	Payment Basis in CBA	Claim for a Beneficiary who Permanently Lives Outside a CBA	Payment Basis outside CBA
Manual Wheelchair (K0001- K0004, K0006, K0007)	Bid in Round 2; (not bid in Round 1)	Bill without KE or KY modifier	Single Payment Amount (SPA)	Bill with KE modifier	Fee Schedule**
Standard Power Wheelchair (K0813 thru K0829)	Bid in Round 2 (bid in Round 1)	Bill without KE or KY modifier	SPA	Bill without KE modifier	Fee Schedule*
Complex Rehabilitative Group 2 Power Wheelchair (K0835 thru K0843) and Complex Rehabilitative Group 3 Power Wheelchair (K0848 thru K0864)	Not bid in Round 2 (bid in Round 1)	Bill with KY modifier	Fee Schedule*	Bill without KE modifier	Fee Schedule*
Manual Wheelchair (K0005, K0009) or Miscellaneous Power Wheelchair (K0898)	Not bid in Round 2 (not bid in Round 1)	Bill with KE modifier	Fee Schedule**	Bill with KE modifier	Fee Schedule**

* Fee schedule amount includes the 9.5% reduction.
** Fee schedule amount includes the 5% covered item update increase.

Claims Processing Rules Summary

Covered claims will be paid for competitively bid (Round 2 or subsequent Round) wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with certain non-competitively bid wheelchair base units at the fee schedule rate, when billed by a non-contract supplier with a "KY" modifier.

Claims will be denied for competitively bid (Round 2 or subsequent Round) wheelchair accessory items furnished to beneficiaries permanently residing in a Round 2 (and all subsequent Rounds) CBA for use with certain non-competitively bid wheelchair base units, when billed by a non-contract supplier without a "KY" modifier.

The following Claims Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), and Group Code will be used on the remittance advice when a claim is denied by the DME MAC:

- CARC 4: The procedure code is inconsistent with the modifier use or a required modifier is missing.
- CARC 16: Claim/service lacks information which is needed for adjudication.
- RARC M114: This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
- RARC MA13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code.
- RARC N519: Invalid combination of HCPCS modifiers.
- RARC N565: Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.
- Group Code: CO

In addition, Medicare will return claims as unprocessable when the KY modifier is submitted by a supplier for accessory items for beneficiaries in a CBA for wheelchairs that are not identified by the HCPCS ranges of K0835-K0843 and K0848-K0864. In returning such claims, Medicare will use:

- CARC 4: The procedure code is inconsistent with the modifier use or a required modifier is missing.

- RARC M114: This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.
- RARC MA13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code.
- RARC MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/corrected information.
- Group Code: CO

Additional Information

The official instruction, CR8181 issued to your DME MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1184OTN.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.

You may review MLN Matters® article MM6119, *Phase 2 Manual Revisions for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program* at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6119.pdf** on the CMS website. MLN Matters® Article SE1244 is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on The Medicare DMEPOS Competitive Bidding Program at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1244.pdf** on the CMS website.

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 **Related Change Request (CR) #: 6421, 6417, 6696, 6856**
Related CR Release Date: N/A **Effective Date: May 1, 2013**
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R7810TN **Implementation Date: May 1, 2013**

Note: *This Special Edition MLN Matters® Article is a consolidation and update of prior articles SE1011, SE1201, SE1208, and SE1221. Effective May 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will turn on the Phase 2 denial edits. This means that Medicare will deny claims for services or supplies that require an ordering/referring provider to be identified and that provider is not identified, is not in Medicare's enrollment records, or is not of a specialty type that may order/refer the service/item being billed.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

Provider Action Needed

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

What Providers Need to Know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. **Phase 2: Effective May 1, 2013, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits.** Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

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 May 1, 2013 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; and
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS.

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

- 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 on a

weekly basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**; click on "Ordering & Referring Information" (on the left). Information about the Report will be displayed.

Phase 2: Effective May 1, 2013, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. Below are the denial edits for Part B providers and suppliers who submit claims to 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 weekly 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.

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

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

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

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.

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.

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers (SE1201) (GEN)

MLN Matters® Number: SE1201 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 MLN Matters® Article was replaced on February 26, 2013, by MLN Matters® Article SE1305. A key element of SE1305 is the announcement that Phase 2 of the ordering/referring provider edits will start on May 1, 2013. On that date, the Phase 2 denial edits will be implemented. For complete and current information on this issue, see SE1305, which is available at* **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf** *on the Centers for Medicare & Medicaid Services (CMS) website.*

Phase 2 of Ordering/Referring Requirement (SE1221) (GEN)

MLN Matters® Number: SE1221 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 MLN Matters® Article was replaced on February 26, 2013, by MLN Matters® Article SE1305. A key element of SE1305 is the announcement that Phase 2 of the ordering/referring provider edits will start on May 1, 2013. On that date, the Phase 2 denial edits will be implemented. For complete and current information on this issue, see SE1305, which is available at* **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf** *on the Centers for Medicare & Medicaid Services (CMS) website.*

Healthcare Provider Taxonomy Codes (HPTC) Update, April 2013 (MM8211) (GEN)

MLN Matters® Number: MM8211
Related CR Release Date: February 15, 2013
Related CR Transmittal #: R2660CP

Related Change Request (CR) #: CR 8211
Effective Date: April 1, 2013
Implementation Date: July 1, 2013 (Contractors who have the capability may implement April 1, 2013 or after)

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8211 which instructs carriers and Part B MACS to obtain the most recent Healthcare Provider Taxonomy Codes (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, among them health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Health care claims are among the health care transactions for which standards were adopted under HIPAA. Among the current versions of the standard implementation guides for health care claim transactions are the 5010 versions of the ASC X12 837 Institutional Technical Report 3 (TR3) for institutional claims and the ASC X12 837 professional TR3 for professional (and some supplier) claims. (There are other standards for other types of claims). Both the current ASC X12 837 institutional and professional TR3s require that the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code (HPTC) set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty.

The standards implementation guides state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code."; and
- "If not required by this implementation guide, do not send."

Medicare does not use HPTCs to adjudicate its claims. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at **http://www.wpc-edi.com/codes** on the Internet.

CR8211 implements the NUCC HPTC code set that is effective on April 1, 2013. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional Information

The official instruction, CR8211, issued to your carriers and B MACs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2660CP.pdf** on the CMS website. If you have any questions, please contact your carriers or Part 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.

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

MLN Matters® Number: SE1249
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

Provider Types Affected

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

Provider Action Needed

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

What You Need to Know

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

Background

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

Key Points

General Information

In the coming months, CMS plans to discontinue access to the CWF queries through the shared systems: MCS PPTN, VMS VPIQ and FISS DDE. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

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

Frequently Asked Questions

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

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

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?
HETS returns all of the information provided by the CWF eligibility queries that is needed to process Medicare claims with the exception of psychiatric information. HETS returns additional information that CWF does not return. For example, HETS returns:

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

HETS returns some information in a format that differs from the CWF format. In addition, there is a change underway to allow HETS to return Hospice information in the same format as CWF. The HETS 270/271 Companion Guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf** on the CMS website.

Additional Information

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

ICD-10 CM–Updates to National Coverage Determination/Local Coverage Determination (NCD/LCD) Processing in the VMS Shared System (MM8207) (GEN)

MLN Matters® Number: MM8207
Related CR Release Date: February 15, 2013
Related CR Transmittal #: R1191OTN
Related Change Request (CR) #: CR 8207
Effective Date: July 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8207 which informs Medicare contractors about the details of the system changes required to accommodate separate National Coverage Determination/Local Coverage Determination (NCD/LCD) codes for policies associated with ICD-9 and ICD-10 diagnosis codes

Background

The Centers for Medicare & Medicaid Services (CMS) is making modifications to its 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 ICD-10 diagnosis code effective date. This article reminds suppliers of the need to be ready for ICD-10 implementation, which will occur on October 1, 2014. An abundance of information is available regarding ICD-10 at **http://www.cms.gov/Medicare/Coding/ICD10/index.html** on the CMS website.

Additional Information

The official instruction, CR8207 issued to your DME/MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1191OTN.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.

Implementation of the PWK (Paperwork) Segment for X12N Version 5010 (MM7041) (GEN)

MLN Matters® Number: MM7041 Revised
Related CR Release Date: April 20, 2011
Related CR Transmittal #: R874OTN

Related Change Request (CR) #: 7041
Effective Date for Providers: July 1, 2011
Implementation Date: July 5, 2011

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

Key Points for Medicare Billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html on the CMS website.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.

- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information

If you have questions, please contact your MAC and/or FI/carrier 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.

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

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

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

Medicare Remit Easy Print (MREP) Enhancement (MM8149) (GEN)

MLN Matters® Number: MM8149
Related CR Release Date: January 18, 2013
Related CR Transmittal #: R1163OTN
Related Change Request (CR) #: CR 8149
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who use Medicare Remit Easy Print (MREP) software.

What You Need To Know

Change Request (CR) 8149, from which this article is taken, instructs the relevant Medicare contractor, Viable Information Processing Systems (ViPS), to add an enhancement to Medicare Remit Easy Print (MREP) software so that it is compatible with additional personal computer operating systems.

Background

The Centers for Medicare & Medicaid Services (CMS) offers free software (Medicare Remit Easy Print (MREP)) to view and print HIPAA compliant Electronic Remittance Advice (Transaction 835 - Health Care Claim Payment/Advice). CMS believes that making the software compatible with multiple operating systems would make it more acceptable to users and providers/suppliers and help the transition from paper to Electronic Remittance Advice (ERA).

Therefore, as part of the regular software enhancement process (designed to meet the changing needs of providers/suppliers to help you transition to ERA), CR7218 (published on November 12, 2010) instructed ViPS to make the MREP compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems. (You can find the related MLN Matters® article, MM7218 (*Medicare Remit Easy Print (MREP) Enhancement*), at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7218.pdf** on the CMS website.)

In response to reports of user issues with MREP, CR8149, from which this article is taken, instructs ViPS to analyze and resolve (effective July 1, 2013) the finding that a ".NET Framework is required by MREP but is incompatible with Windows 7."

Your carrier, B MAC, or DME MAC will notify you (effective July 1, 2013) of the enhancement in MREP software once the resolutions are implemented.

Additional Information

The official instruction, CR8149, issued to your carrier, B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1163OTN.pdf** on the CMS website. If you have any questions, please contact your carrier, 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.

Prescription Drug Monitoring Programs: A Resource to Help Address Prescription Drug Abuse and Diversion (SE1250) (DRU)

MLN Matters® Number: SE1250
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

Provider Types Affected

This MLN Matters® Special Edition Article about Prescription Drug Monitoring Programs (PDMPs) is intended for physicians, pharmacists, nurses, and other health care providers that prescribe or dispense scheduled drugs.

What You Need to Know

Prescription drug abuse and diversion are acute problems in the area of pain management. Efforts to improve the management of pain create a dilemma for physicians and other providers, who have to balance legitimate patient therapeutic needs against what may be potential abuse or drug diversion activities due to the drug-seeking behavior of their patients.

Most States have operational PDMPs that collect data on prescriptions of controlled substances in order to provide resources to reduce prescription drug abuse and diversion. If you enroll in your state's PDMP, you may get reports to help you identify patients who are obtaining prescriptions from other doctors or from multiple pharmacies, or who may be at risk for prescription drug abuse. A PDMP report may be particularly useful before prescribing controlled substances for new patients. Visit **http://www.pmpalliance.org/content/prescription-monitoring-frequently-asked-questions-faq** for more information and links to your state's PDMP.

Background

PDMPs are statewide electronic databases that collect prescription dispensing data of controlled substances. Legislation authorizing collection of data is currently in place in 49 states with 41 states having a functional PDMP (*Clark T, Eadie J, Kreiner P, Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. The PDMP Center of Excellence, Heller School for Social Policy and Management, Brandeis University. September 20, 2012.*). These databases were originally implemented as an effort to address controlled substance abuse and reduce diversion.

Despite the proliferation of PDMPs, not all of them function in the same manner. The agencies that are responsible for housing and monitoring these programs vary across states but are typically located in either the state's Board of Pharmacy, Department of Health and Human Services, or law enforcement agencies. States have a say on what type of controlled substances are tracked (CII-V) and may include other prescription drugs such as tramadol, carisoprodol, or butalbital.

Many PDMPs provide secure online access to authorized users including physicians and pharmacists. These monitoring programs can report dispensing dates, prescriber, pharmacy, drug name, quantity, and strength of controlled substance prescriptions, including opioids.

Although the focus of PDMPs was originally intended to help reduce drug diversion and abuse, they can also be used for improving medical care and ensuring safe use of controlled substances. Improving the prescribing of controlled substances can reduce their diversion and abuse. Identifying abusers for treatment can improve the public's health.

Need for Action

Abuse of prescription drugs is considered the nation's fastest growing drug-problem. Average sales of opioids per person have increased from 74 milligrams to 369 milligrams between 1997 and 2007, a 402% increase. The Centers for Disease Control and Prevention (CDC) reported that the estimated number of emergency department visits for non-medical use of opioid analgesics increased 111% during 2004-2008 (from 144,600 to 305,900 visits). In addition, drug overdoses, including those from prescription drugs, were the second leading cause of deaths from unintentional injuries in the United States during 2007, exceeded only by motor vehicle fatalities (*Unintentional drug poisoning in the United States [July 2010]. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention.* ***http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf***.).

Movements to improve pain assessment and control have increased the awareness among physicians and patients on the need for analgesics, fueling the nation's consumption, which ranks among the highest in the world. This increased attention to better managing pain creates a dilemma for prescribers who must appropriately prescribe potent opioids for the treatment of pain while being mindful of the possibility that certain individuals may be seeking prescriptions for non-medical purposes or to satisfy an addiction.

Don't be duped into believing "not my Medicare patient." A recent U.S. Government Accountability Office (GAO) report titled "Medicare Part D: Instances of Questionable Access to Prescription Drugs," identified 170,000 Medicare beneficiaries who received prescriptions from five or more prescribers and often receiving 2-4 times a normal year's supply. The most frequently prescribed drugs were hydrocodone with acetaminophen and oxycodone alone or in combination. When samples of these cases were reviewed with the prescribing physicians, none were aware of the other prescribers. In many cases, the beneficiary had signed a pain management agreement but continued to 'doctor shop.' Beginning in 2013, due to the risks of adverse effects from misuse of opioid analgesics, the Centers for Medicare and Medicaid Services (CMS) will require Medicare Part D plans to contact prescribers to ascertain the medical necessity of potentially unsafe, high opioid dosages used for chronic, non-cancer pain. For more information about the requirements for Medicare Part D sponsors to manage the use of opioids in their prescription drug plans, go to **http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html** on the CMS website.

With added involvement and interventions from prescribers and pharmacists, PDMPs are one step towards resolving inappropriate or unsafe controlled substance prescription use by the identification of 'doctor shoppers' and detecting therapeutic duplication. Most states require pharmacies to report controlled substance prescription data at least biweekly to their PDMP. This consistent and up-to-date monitoring could prevent the dispensing of unnecessarily high amounts of controlled substance prescriptions at either the physician visit or dispensing pharmacy - a more direct and time efficient method.

A recent report assessing the best practices of PDMPs identified 6 areas for further development (*Clark T, Eadie J, Kreiner P, Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. The PDMP Center of Excellence, Heller School for Social Policy and Management, Brandeis University. September 20, 2012.*). One area of special note was increasing medical provider education and encouraging the use of PDMPs as a clinical tool. This second area is the natural extension of PDMP data into the broader areas of improving public health and safety.

Provider Action

PDMP records may help you determine if a patient is obtaining prescriptions from other doctors or from multiple pharmacies. We encourage you to actively participate in your state's PDMP:

- Determine if your state has a PDMP and how you can access the data by visiting **http://www.pmpalliance.org/content/state-pmp-websites** on the Internet.

- Consider developing an office protocol to request a PDMP report for all new patients receiving a controlled substance. Additionally, a periodic PDMP report could be requested if pain control is for a chronic condition to assure that the patient is properly managing their medications.

Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update (MM8154) (GEN)

MLN Matters® Number: MM8154
Related CR Release Date: December 21, 2012
Related CR Transmittal #: R2618CP

Related Change Request (CR) #: CR 8154
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8154 which instructs Medicare contractors and Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been added since the last recurring code update. It also instructs Medicare System maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

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

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

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

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

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR8154, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only 3 times a year and may not match the CMS schedule for releasing its system updates.

CR8154 lists only the changes that have been approved since the last code update CR (CR 8029, Transmittal 2521, issued on August 17, 2012), and does not provide a complete list of codes for these two code sets.

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

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

Note: *In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented.*

The CARC and RARC changes reflected by CR8154 are as follows:

New Codes - CARC:

Code	Code Narrative	Effective Date
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	9/30/2012
245	Provider performance program withhold.	9/30/2012
246	This non-payable code is for required reporting only.	9/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare Bundled Payment use only, under the *Patient Protection and Affordable Care Act* (PPACA).	9/30/2012
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare Bundled Payment use only, under the *Patient Protection and Affordable Care Act* (PPACA).	9/30/2012
249	This claim has been identified as a resubmission. (Use only with Group Code CO)	9/30/2012
250	The attachment content received is inconsistent with the expected content.	9/30/2012
251	The attachment content received did not contain the content required to process this claim or service	9/30/2012
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9/30/2012
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	9/30/2012
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	9/30/2012
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.	9/30/2012

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
18	Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)	1/1/2013
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	9/30/2012
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	9/30/2012
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. (Use only with Group Code OA)	9/30/2012
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	7/1/2013
173	Service was not prescribed by a physician. This change effective 7/1/2013: Service/equipment was not prescribed by a physician.	7/1/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	7/1/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	7/1/2013
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	9/30/2012
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	9/30/2012
221	Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	9/30/2012
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	7/1/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	7/1/2013

Code	Modified Narrative	Effective Date
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee	7/1/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	7/1/2013

Deactivated Codes - CARC: None

New Codes - RARC:

Code	Code Narrative	Effective Date
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.	11/1/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.	11/1/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	11/1/2012
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	11/1/2012
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	11/1/2012
N565	Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.	11/1/2012
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.	11/1/2012

Modified Codes - RARC:

Code	Modified Narrative	Effective Date
M39	The Note: (Modified 2/1/04, 4/1/07, 11/1/09) Related to N563	11/1/2012
M137	Part B coinsurance under a demonstration project or pilot program.	11/1/2012

Deactivated Codes - RARC:

Code	Narrative	Effective Date
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	11/1/2012

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the Business Requirements segment of CR8154 for an explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional Information

The official instruction, CR8154 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2618CP.pdf** on the CMS website. For more information on CARC and RARC codes go to **http://www.wpc-edi.com/Reference** on the internet. 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.

Revision to CWF and VMS: Reject or Informational Unsolicited Response (IUR) Edit for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Provided During an Inpatient Stay (MM8172) (GEN)

MLN Matters® Number: MM8172
Related CR Release Date: February 8, 2013
Related CR Transmittal #: R1183OTN
Related Change Request (CR) #: CR 8172
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for hospitals and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for DMEPOS items provided to Medicare beneficiaries while an inpatient in a hospital.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8172 to alert hospitals and DMEPOS suppliers that claims for DMEPOS items to beneficiaries received in a covered inpatient stay are considered an overpayment and may be rejected or line item denied. DMEPOS suppliers are encouraged to review this article in order to avoid potential overpayment situations.

Background

The CMS Recovery Auditor program is responsible for identifying and correcting improper payments in the Medicare Fee-For-Service (FFS) payment process. The claim data used by the Recovery Auditors identified DMEPOS claims for beneficiaries who received DMEPOS items while in an inpatient stay in a hospital. The payments associated with these claims are considered overpayments because Medicare does not allow separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. These claims were related to DME date of service greater than 2 days prior to Part A discharge date or Part A discharge status was not to home. CR8172 will result in the Common Working File (CWF) creation of a line item rejection for these claims if DMEPOS Claim Status is unpaid or a line item IUR if DEMPOS Claim Status is paid. An IUR results in the investigation of the claim by the DME MAC to determine if an overpayment was made.

Key Points

According to the "*Medicare Claims Processing Manual*," Chapter 20, Section 210, the DMEPOS benefit is meant only for items a beneficiary is using in his or her home:

- For a beneficiary in a Part A inpatient stay, an institutional provider (e.g., hospital) is not defined as a beneficiary's home for DMEPOS, and so Medicare does not make separate payment for DMEPOS when a beneficiary is in the institution. The institution is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

According to the "*Medicare Claims Processing Manual*," Chapter 20, Section 110.3.1, in some cases, it would be appropriate for a supplier to deliver a medically necessary item of Durable Medical Equipment (DME), a prosthetic, or an orthotic, but not supplies to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home. CMS presumes that the pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter "item") is appropriate when all the following conditions are met:

1. The item is medically necessary for use by the beneficiary in the beneficiary's home;
2. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use;
3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home;
4. The supplier delivers the item to the beneficiary no earlier than two days before the day the facility discharges the beneficiary;
5. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge;

6. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates;
7. The supplier does not claim payment for the item for any day prior to the date of discharge;
8. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery; and
9. The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility), but not to another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home.

According to the "*Medicare Claims Processing Manual*," Chapter 20, Section 110.3.2 for DMEPOS, the general rule is that the date of service is equal to the date of delivery. Pre-discharge deliveries of items intended for use upon discharge are considered provided on the date of discharge. The following three scenarios demonstrate both the latter rule (when the date of service is the date of discharge) and related exceptions.

1. If the supplier leaves the item with the beneficiary two days prior to the date of discharge, and if the supplier, as a practical matter, need do nothing further to effect the delivery of the item to the beneficiary's home (because the beneficiary or a caregiver takes it home), then the date of discharge is deemed to be the date of delivery of the item. Such date must be the date of service for purposes of claims submission. (This is not an exception to the general DMEPOS rule that the date of service must be the date of delivery. Rather, it recognizes the supplier's responsibility - per condition five above - to ensure that the item is actually delivered to the beneficiary's home on the date of discharge.) No one may bill for the days prior to the date of discharge.
2. If the supplier fits the item to the beneficiary, or trains the beneficiary in its use while the beneficiary is in the facility, but thereafter removes the item and subsequently delivers it to the beneficiary's home, then the date of service must be the date of actual delivery of the item, provided such date is not earlier than the date of discharge.
3. If the supplier leaves the item at the facility and the beneficiary does not take the item home, or a third party does not send it to the beneficiary's home, or the supplier does not otherwise (re)deliver the item to the beneficiary's home on or before the date of discharge, the date of service must not be earlier than the actual date of delivery of the item, i.e., the actual date the item arrives, by whatever means, at the beneficiary's home.

Additional Information

You can find the official instruction, CR8172, issued to your DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1183OTN.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.

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

MLN Matters® Number: MM8182
Related CR Release Date: February 8, 2013
Related CR Transmittal #: R1187OTN

Related Change Request (CR) #: CR 8182
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 (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/R1187OTN.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.

Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (MM7836) (SPE)

MLN Matters® Number: MM7836 Revised
Related CR Release Date: November 30, 2012
Related CR Transmittal #: R2605CP and R149NCD

Related Change Request (CR) #: CR 7836
Effective Date: June 8, 2012
Implementation Date: January 7, 2013

Note: *This article was revised on December 4, 2012, to reflect a revised CR7836, issued on November 30, 2012. In this article, the CR transmittal numbers, release date, and the Web address for accessing CR7836 have been revised. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare contractors (carriers, Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Transcutaneous Electrical Nerve Stimulation (TENS) services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7836 which informs providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is revising the coverage for TENS for Chronic Low Back Pain (CLBP) effective for claims with dates of service on or after June 8, 2012. See the Key Points section of this article for specific coverage rules and review the lists of ICD- 9 and ICD-10 codes attached to the official instruction CR7836.

Background

In 2010, the Therapeutic and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published a report finding TENS ineffective for CLBP. CMS internally initiated a new national coverage determination (NCD) after the AAN published report and reviewed all the available evidence on the use of TENS for the treatment of CLBP.

Medicare has four NCDs pertaining to various uses of TENS that were developed before the CMS adoption of an evidence based and publicly transparent paradigm for coverage decisions. Those four NCDs are:

- Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2);
- Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1);
- Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13); and

- Transcutaneous Electrical Nerve Stimulators (TENS) (280.13). *Please note, section 280.13 has been removed from the NCD manual and incorporated into NCD 160.27*

The evidentiary basis is unclear for historic coverage. TENS has been historically thought to relieve chronic pain but the current evidence base refutes this assertion when applied to TENS for CLBP. Since TENS falls within the durable medical equipment (DME) benefit, Medicare coverage results in purchase after a brief initial rental period, even if the patient soon develops a subsequent tolerance to the TENS effect.

Key Points

Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will only allow coverage of TENS for CLBP defined for this decision as pain for 3 months or longer and not a manifestation of a clearly defined and generally recognizable primary disease entity, when the patient is enrolled in an approved clinical study under coverage with evidence development (CED).

Note: *CED coverage expires three years from the effective date of this CR, June 8, 2015.*

Examples of clearly defined and recognizable primary disease entities: neurodegenerative (e.g. multiple sclerosis) disease, malignancy, or well-defined rheumatic disorders (except osteoarthritis).

Medicare contractors will accept and process line items that include an appropriate TENS HCPCS code, at least one ICD-9 diagnosis code for CLBP (see list of ICD-9 codes attached to CR7836), and all of the following:

- Date of service on or after June 8, 2012;
- Modifiers KX and Q0;
- ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only);
- Condition code 30 - (for institutional claims only)
- An acceptable ICD-9 code; and
- An acceptable ICD-10 code upon implementation (see list of ICD-10 codes attached to CR7836).

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2605CP of CR7836 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf**), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group Code CO;
- Claim Adjustment Reason Code B5 (Coverage/program guidelines were not met or were exceeded.); and
- Remittance Advice Remark Code N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at **http://www.cms.gov/mcd/search.asp**. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Medicare will pay for allowed TENS for CLBP based on the DME fee schedule.

All of the following conditions must be met for coverage of TENS for CLBP:

CLBP is defined as:

- An episode of low back pain that has persisted for three months or longer; and
- **Is not the manifestation of a clearly defined and generally recognizable primary disease entity.**

For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom. Certain systemic diseases, e.g. rheumatoid arthritis, multiple sclerosis etc, manifest many debilitating symptoms of which low back pain is not the primary focus. CMS believes that the appropriate management of these types of diseases is guided by a systematic strategy aimed at the underlying causes. While TENS may infrequently be used adjunctively in managing the symptoms of these diseases, it is clearly not the primary therapeutic approach.

The patient is enrolled in an approved clinical study that addresses one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.

1. Does the use of TENS provide a clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
2. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
3. Does the use of TENS provide a clinically meaningful reduction in other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R149NCD of CR7836. That transmittal is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf** on the CMS website.

Additional Information

The official instruction, CR 7836, issued to your Medicare Carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the *NCD Manual* and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R149NCD.pdf** on the CMS website. The other transmittal updates the "*Medicare Claims Processing Manual*" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2605CP.pdf** on the CMS website. If you have any questions, please contact your carrier, 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.

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2013 (MM8052) (GEN)

MLN Matters® Number: MM8052
Related CR Release Date: December 7, 2012
Related CR Transmittal #: R81GI

Related Change Request (CR) #: CR 8052
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8052 which informs Medicare contractors about the changes needed to update the claims processing system with the new Calendar Year (CY) 2013 Medicare rates. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

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

A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

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

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

The following deductible and coinsurance rates apply for 2013.

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

- 2013 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)
  - Standard Premium - $104.90 a month
  - Deductible - $147.00 a year
  - Coinsurance - 20 percent

Additional Information

The official instruction, CR8052 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R81GI.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.

CMS News Flash (GEN)

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at **http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html** on the Centers for Medicare & Medicaid Services (CMS) website. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare.

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? 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!

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!

Re-released products from the Medicare Learning Network® (MLN)

- "*How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS),*" Fact Sheet, ICN 905103, Downloadable only.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243391.html

Re-released products from the Medicare Learning Network® (MLN)

- "*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

Revise products from the Medicare Learning Network® (MLN)

- "*Basic Medicare Information for Providers and Suppliers,*" Guide, ICN 005933, Downloadable only.
  http://www1d.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Basic-Medicare-Information-for-Providers-and-Suppliers-Guide-ICN005933.pdf

Flu Season is Here - According to the Centers for Disease Control and Prevention, flu activity is beginning to increase and further increases are expected in the coming weeks and months. Now is the time to protect against flu before activity increases in the community. About 5 to 20 percent of the population gets the flu each year and more than 200,000 people are hospitalized because of flu-related complications. Make each office visit an opportunity to talk with your patients about the importance of getting an annual flu vaccination and a pneumococcal vaccination according to the recommended schedule. This message also serves as a reminder for you to get your seasonal flu vaccination to protect yourself, your family, and your patients.

Remember - the Influenza and pneumococcal vaccines and their administration fees are covered Part B benefits. Influenza and pneumococcal vaccines are NOT Part D-covered drugs.

CMS has posted the 2012-2013 Seasonal Influenza Vaccines Pricing List (**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html**). You may also refer to the 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**)

Please visit the *CMS Medicare Learning Network® Preventive Services Educational Products* (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html**) and CMS Immunizations (**http://www.cms.gov/immunizations**) web pages for more information on coverage and billing of the flu and pneumococcal vaccines and their administration fees.

While some providers may offer the flu vaccine, those who don't can help their patients locate a vaccine provider within their local community. The *HealthMap Vaccine Finder* (**http://flushot.healthmap.org/**) is a free, online service where users can find nearby locations offering flu vaccines.

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

- 2012-2013 Seasonal Influenza Vaccines Pricing (**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html**). MLN Matters® Article MM8047, "*Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season*" (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf**).
- "CMS Medicare Learning Network® 2012-2013 Seasonal Influenza Virus Educational Products and Resources (**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Flu_Products.pdf**) and CMS Immunizations (**http://www.cms.gov/immunizations**) web pages for information on coverage and billing.
- HealthMap Vaccine Finder (**http://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 website (**http://www.cdc.gov/flu/freeresources/**) offers a variety of provider resources for the 2012-2013 flu season.

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**).

CMS e-News Links (GEN)

December

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

CMS e-News for Thursday, December 13, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews121312.pdf

CMS e-News for Thursday, December 20, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/eNews-12202012.pdf

January

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

CMS e-News for Thursday, January 10, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-10-Enews.pdf

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

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

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

February

CMS e-News for Thursday, February 07, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-07-Enews.pdf

CMS e-News for Thursday, February 14, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-14-Enews.pdf

CMS e-News for Thursday, February 21, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-21-enews.pdf

CMS e-News for Thursday, February 28, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-02-28Enews.pdf

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:

- 1st Quarter 2013 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2013 Oral Anticancer Drug Fees
- 2013 Fees for Repairs/Labor (CR8133)

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.

2013 Fees for Repairs/Labor (CR8133) (GEN)

Payment is allowed for reasonable and necessary repairs or nonroutine service of beneficiary-owned DMEPOS if not otherwise covered under an equipment warranty.

The below table identifies the 2013 fee schedule for K0739, L4205, L7520 for dates of service on or after January 1, 2013, through December 31, 2013.

State	K0739	L4205	L7520
CT	23.87	21.77	28.91
DC	14.29	21.28	28.91
DE	26.32	21.28	28.91
MA	23.87	21.28	28.91
MD	14.29	21.28	28.91
ME	23.87	21.28	28.91
NH	15.34	21.28	28.91
NJ	19.28	21.28	28.91
NY	26.32	21.30	28.91
PA	15.34	21.91	28.91
RI	17.03	21.93	28.91
VT	15.34	21.28	28.91

Fax Submission Tips and Reminders (GEN)

DME MAC Jurisdiction A receives many incoming faxes on a daily basis and would like to offer the following suggestions to ensure a smooth process:

Faxes are accepted for Reopening, Redetermination, Overpayment, and General Inquiry Requests as well as responses to Automated Development Requests (ADR).

Following the fax guidelines listed below will ensure the prompt receipt and accurate department assignment of your fax:

- Be sure your fax machine is set for the correct date. This date should be the date you are faxing to NHIC.
- Send each fax as a separate submission. Combining multiple fax requests into a single fax may cause a delay in routing the faxes to the appropriate area for processing.
- A fax should contain all requested documentation. Do not send multiple faxes as a response to one request for documentation.
- Check that all pages are right side up, with the top of each page at the top of your fax machine, before faxing.
- Complete the correct form when sending your request. Please visit the "forms" page of our web site at **http://www.medicarenhic.com/dme/dme_forms.shtml**
- Using the correct fax number will assist in routing faxes to the correct department. The following fax numbers should be used:

  781-741-3118 - Redetermination Requests/Written inquiries
  781-741-3914 - Reopening Requests
  781-383-4513 - Overpayment Requests
  781-741-3916 - Immediate offset requests
  781-741-3833 - Medical Review ADR responses
  781-741-3991 - Medical Review ADMC Requests
  781-741-3545 - Documented Compliance Review (DCR) ADR responses.
  781-383-4519 - PMD Prior Authorization Requests

- If responding to a request for documentation, please send a copy of the request with the documentation. It is helpful for the request to be at the beginning of your fax to speed departmental routing.
- If you have requests or documentation for different NPI numbers, please fax separately as each fax must receive a unique control number for processing purposes.
- Please be sure your office receives a confirmation that all pages of the fax were received. Only complete faxes will be submitted for processing.
- Consider mailing requests with multiple pages. Depending on the size of the document and the condition of the documentation, mailing the documentation may be the better option than faxing. Contact information, including mailing addresses can be found at **http://www.medicarenhic.com/dme/contacts.shtml**

1099-MISC Form Information (GEN)

NHIC, Corp. will mail all 1099 Forms for calendar year (CY) 2012 on January 30, 2013. Suppliers can expect 1099 Forms to arrive within 7-10 business days from the date of mailing.

Medicare suppliers and beneficiaries who are serviced by NHIC, Corp. will receive a single Part A, Part B, and Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC) combined by TIN from NHIC for CY 2012.

In accordance with the Internal Revenue Code, contractors are required to issue 1099-MISC forms to all suppliers that received payments greater than $600 within the calendar year. Any questions pertaining to the receipt or amount recorded on your 1099-MISC should be directed to:

NHIC, Corp
Attn: Written Inquiries
PO Box 9146
Hingham, MA 02043-9146

Common Question/Concerns

What should I do if I did not receive a 1099?

Verify that you have received greater than $600 in payments and that your mailing address is current at the National Supplier Clearinghouse (NSC). If the answer is yes to both of these questions, contact the NHIC, Corp. Customer Service Department at 866-590-6731.

What address will my 1099 be mailed to?

1099's are mailed to the address on record with the NSC.

My mailing address is not current at the National Supplier Clearinghouse.

A new 855 form will need to be submitted to the NSC. Once the address is updated, contact the NHIC, Corp. Customer Service Department at 866-590-6731 and request that a duplicate 1099 be issued.

My 1099 has been misplaced, how can I obtain a duplicate?

Send a written request to the NHIC, Corp. Written Inquiries Department address above or contact the NHIC, Corp. Customer Service Department at 866-590-6731.

How was the figure reported in Box 6 (Medical and health care payments) calculated?

The 1099 amount is calculated by totaling the amount of money paid to the supplier during the reporting year (this includes claim payments that were offset on established account receivables).

I have verified my records and do not agree with the amount reported on the 1099.

Send a letter to the NHIC, Corp. Written Inquiries Department detailing your concern.

A 1099-MISC was received but I am tax-exempt.

NHIC, Corp is required to issue 1099-MISC form in accordance with the Internal Revenue Code. It is the responsibility of the supplier to contact the IRS pertaining to tax status and reporting requirements.

The Tax Identification Number is incorrect on my 1099-MISC.

The Tax Identification Number recorded on the 1099 is the number that is on record at the NSC. A new 855 form will need to be submitted to the NSC to correct your TIN.

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

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

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LCD Revisions Summary for December 28, 2012 (GEN)

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

Glucose Monitors

LCD

Revision Effective Date: 11/01/2012 (December Publication)

INDICATIONS AND LIMITATIONS OF COVERAGE:

Clerical Correction: Re-inserted documentation requirement for high utilization beneficiaries inadvertently omitted from 11/01/2012 publication.

DOCUMENTATION REQUIREMENTS:

Added: Consumable and non-consumable supplies to Refill documentation

Deleted: Method 3 under Proof of Delivery (Delivery to nursing facility) since this does not apply to DME

Clerical Correction: Re-inserted documentation requirement for high utilization beneficiaries inadvertently omitted from 11/01/2012 publication.

Clerical Correction: Consolidated redundant written order requirements in Policy Specific Documentation Requirements

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

LCD and Policy Article Revisions Summary for February 22, 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.

Automatic External Defibrillators

LCD

Revision Effective Date: 01/01/2011 (February 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.*)

External Infusion Pumps

LCD

Revision Effective Date: 07/22/2011 (February 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE:
- Added: J1569 to Subcutaneous immune globulin section
- Added: Refill requirements (Standard language) (Effective 08/04/2011)

HCPCS CODES AND MODIFIERS:
- Added: J1569

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
- Added: J1569

DOCUMENTATION REQUIREMENTS:
- Added: J1569 to JB modifier requirement
- 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.*)
- Added: Clarification for use of a revised DIF when a change in drug or HCPCS occurs

Policy Article

Revision Effective Date: 01/01/2013
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
- Added: Preamble
- Added: DME benefit category statement
- Added: Drugs as a supply only benefit statement

Facial Prostheses

LCD

Revision Effective Date: 01/01/2010 (February 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
- 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.*)

Policy Article

Revision Effective Date: 04/01/2013
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
- Added: Benefit Category Standard Language
- 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 February 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.

Canes and Crutches

LCD

Revision Effective Date: 02/04/2011 (February 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
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Standard Language
CODING GUIDELINES:
Added: Coding definition for codes E0117 and E0118

Commodes

LCD
Revision Effective Date: 02/04/2011 (February 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
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
Added: Benefit Category Standard Language

Eye Prosthesis

LCD
Revision History Effective Date: 07/01/2007 (February 2013 Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
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.*)

Policy Article
Revision Effective Date: 04/01/2013
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
Added: Standard Language

Immunosuppressive Drugs

LCD
Revision Effective Date: 01/01/2013
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Language for clarification and addition of CMS IOM references
HCPCS CODES AND MODIFIERS:
Added: J0485
Changed: J8561 to J7527 for Everolimus, oral, 0.25mg
DOCUMENTATION REQUIREMENTS:
Revised: KX and GY Modifiers language for clarification and addition of CMS IOM references

Policy Article

Revision Effective Date: 1/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Language for clarification and addition of CMS IOM reference

Walkers

LCD

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

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Replaced reference to patient with beneficiary

HCPCS CODES AND 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.*)

Revised: Prescription requirements

Added: General medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Added: GY modifier instruction

Revised: Updated HCPCS range reference with modifier usage

Policy Article

Revision Effective Date: 12/01/2009 (February 2013 Publication)

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES

Added: Preamble and SSA reference

Added: Benefit category statement

CODING GUIDELINES:

Added: Rollator verbiage and PDAC verification

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.*

AFO/KAFO LCD related Policy Article - Revised (O&P)

The related Policy Article for the Ankle-Foot Orthosis/Knee-Ankle-Foot Orthosis is being revised. The Policy Article with an effective date of January 1, 2013 included Coding Guidelines for AFOs that included a height requirement. The height requirement is being removed. The effective date for the revised Policy Article is for dates of service on or after January 1, 2013.

Glucose Monitors and Supplies LCD - Clerical Correction (SPE)

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

d. The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary.
e. The treating physician has seen the beneficiary and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

The statement in criterion d regarding documentation in the beneficiary's medical record describing the specific reason(s) for the additional supplies was inadvertently omitted from the revised and consolidated coverage criteria in the LCD effective 11/01/2012. The LCD is being republished with the language reinstated in criteria b. Criterion b now reads:

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,

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

Transcutaneous Electrical Nerve Stimulators (TENS) Sold Over-the-Counter - Coding Guidelines (SPE)

The Food and Drug Administration (FDA) has several product classifications for TENS devices, one of which is designated for TENS devices that may be sold over-the-counter (OTC). OTC TENS are identified with FDA product code NUH. OTC TENS are not considered durable medical equipment (DME). OTC TENS must be coded using HCPCS code:

A9270 - Non-covered item or service

Contact the Pricing, Data Analysis and Coding (PDAC) contractor for more information about the correct coding for TENS.

Refer to the *Supplier Manual*, Transcutaneous Electrical Nerve Stimulation Devices LCD and Related Policy Article for additional information.

Breathe NIOV™ - Coding Reminder - E1399 - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS (OXY)

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

E1399 - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS

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

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

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

Progressive Corrective Action (PCA) (GEN)

PCA is an operational principle upon which all medical review activities are based. PCA involves data analysis, error detection, validation of errors, provider education, determination of review type, sampling claims and payment recovery. It serves as an approach to performing medical review and assists contractors in deciding how to deploy medical review resources and tools appropriately.

The Medicare Administrative Contractor (MAC) may use any relevant information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with our manuals, through a process known as Additional Documentation Request (ADR).

Additional Documentation Request (ADR)

The ADR will include a specific list of the documents the supplier is requested to provide within 45 days from the date of the notification letter. The Medical Review clinician will always need a copy of the written order, shipment or delivery documentation, and any other documentation specified in the LCD for the HCPCS code being reviewed. The supplier will also be required to send copies of actual medical records (not just supplier forms, physician attestations, etc.) that support the medical necessity for the item(s) being reviewed.

Suppliers are reminded that other Medicare contractors often develop claims for additional records. It is therefore very important for suppliers to read any Medicare correspondence thoroughly and carefully follow the instructions for submitting copies of the requested documents.

If the 45 day response time frame is nearing and only a partial response is available, please wait to respond until you have all the required documents if you expect to have them within a few days. This is the recommended practice, rather than submitting a partial response, receiving a denial and then submitting a redetermination request with the remaining information.

If your response is received within a reasonable time frame after your claim has denied for lack of response, it can be reopened and reviewed.

Per the *Medicare Program Integrity Manual* (Pub 100-08), Chapter 3, section 3.2.3.9 - Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information:

> *(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)*
>
> *If the MACs and CERT receive the requested information from a provider or supplier after a denial has been issued but within a reasonable number of days (generally 15 calendar days after the denial date), they have the discretion to reopen the claim.*

Review Results

Medical Review will publish an educational result article after completion of a widespread review (service or code specific) or send a written summary of findings in a letter directly to the supplier after completion of a targeted review (supplier specific). This summary will explain the reviewer's decisions, cite the Medicare policies and regulations that the decisions were based on, and offer supplier education. The article or letter will also provide the paid claims error rate, explain how the error rate was calculated and list the corrective actions that NHIC, Corp. DME MAC will take to correct the identified errors if needed. All educational result articles for widespread reviews can be found on the NHIC Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Corrective Actions

When an error has been validated through Medical Review, the corrective action imposed by the MACs should match the severity of the error. PCA is a means of evaluating the relative risk of the error and assigning appropriate corrective actions.

Whenever a probe review identifies claim errors, supplier education will be one of the corrective actions in Medical Review's error reduction plan. Overpayments will be assessed when errors are identified in postpayment probe reviews and in previously paid claims related to prepayment claim reviews. Other corrective actions may include requiring a supplier to submit a corrective action plan, initiating prepayment claim review, expanding reviews to additional HCPCS codes, referral to other Medicare contractors, and

payment suspensions. Medical Review implements corrective actions commensurate with the initial error rate and level of concern or severity of errors.

For additional information, please refer to: The *Medicare Program Integrity Manual* Chapter 3 - Verifying Potential Errors and Taking Corrective Actions 3.2 - Overview of Prepayment and Postpayment Reviews (**https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf**)

Appeal Rights

Suppliers have appeal rights on review claim denials. Appeals must be filed within 120 days of the Remittance Notice date on a prepayment review claim or from the date on the Overpayment Recoupment letter in the case of a postpayment review claim. Refer to the *DME MAC A Supplier Manual* Chapter 8 - Reopenings and Appeals (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) instructions on filing an appeal. Please do not send appeal requests to Medical Review.

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 74.2%. A summary of findings was published on the NHIC web site on August 24, 2012. Based on this result, a widespread prepayment review was continued.

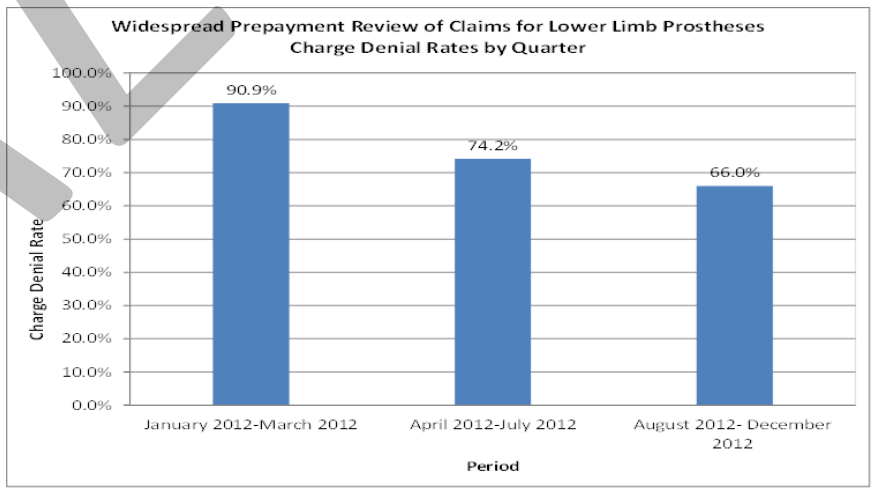
Current Review Results

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 280 claims submitted by 162 suppliers for claims processed August 2012 to December 2012. Responses to the Additional Documentation Request (ADR) were not received for 21 (7%) of the claims. For the remaining 259 claims, 79 claims were allowed and 180 were denied resulting in a claim denial rate of 69%. 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 66%.

Charge Denial Rate Historical Data

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



Primary 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

- 44% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 3% 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

- 22% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 3% of the denied claims were missing the proof of delivery.

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 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. An invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item.

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 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 beneficiaries name, specific items dispensed, treating physicians signature and date, and the start date of order; proof of delivery, validating that the beneficiary received the items that were billed; an invoice of the items, which includes the manufacturer, model numbers and cost of each item; 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/medical_review/mr_bulletins/mr_bulletin_current/phy_letter_artificial_limbs.pdf
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_doc.pdf
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses - Posted August 24, 2012
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/082412_llp.pdf
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses - Posted April 20, 2012
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/042012_llp.pdf
- Results of Widespread Prepayment Probe for Lower Limb Prostheses - Posted November 30, 2011
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/113011_llp.pdf

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 74.2%. A summary of findings was published on the NHIC web site on August 24, 2012. Based on this result, a widespread prepayment review was continued.

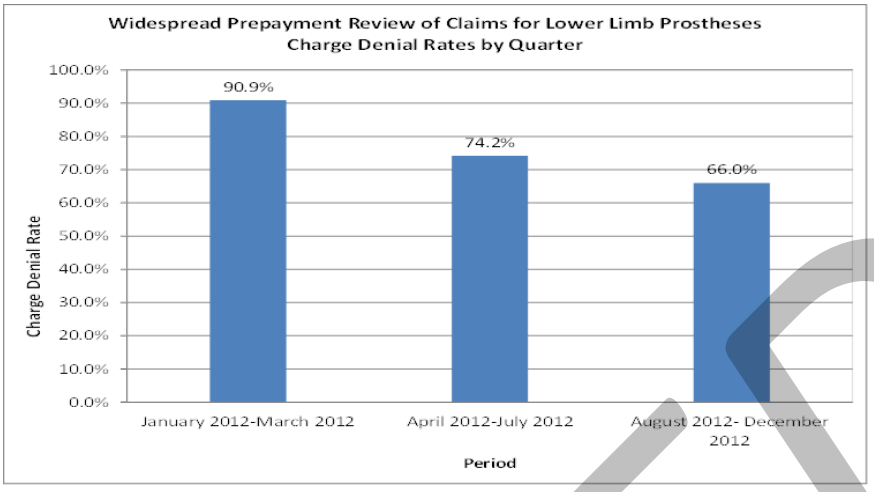
Current Review Results

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 280 claims submitted by 162 suppliers for claims processed August 2012 to December 2012. Responses to the Additional Documentation Request (ADR) were not received for 21 (7%) of the claims. For the remaining 259 claims, 79 claims were allowed and 180 were denied resulting in a claim denial rate of 69%. 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 66%.

Charge Denial Rate Historical Data

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



Primary 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

- 44% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 3% 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

- 22% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 3% of the denied claims were missing the proof of delivery.

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 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. An invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item.

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 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 beneficiaries name, specific items dispensed, treating physicians signature and date, and the start date of order; proof of delivery, validating that the beneficiary received the items that were billed; an invoice of the items, which includes the manufacturer, model numbers and cost of each item; 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/medical_review/mr_bulletins/mr_bulletin_current/phy_letter_artificial_limbs.pdf
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_doc.pdf
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses - Posted August 24, 2012
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/082412_llp.pdf
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses - Posted April 20, 2012
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/042012_llp.pdf
- Results of Widespread Prepayment Probe for Lower Limb Prostheses - Posted November 30, 2011
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/113011_llp.pdf

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

Historical Review Results

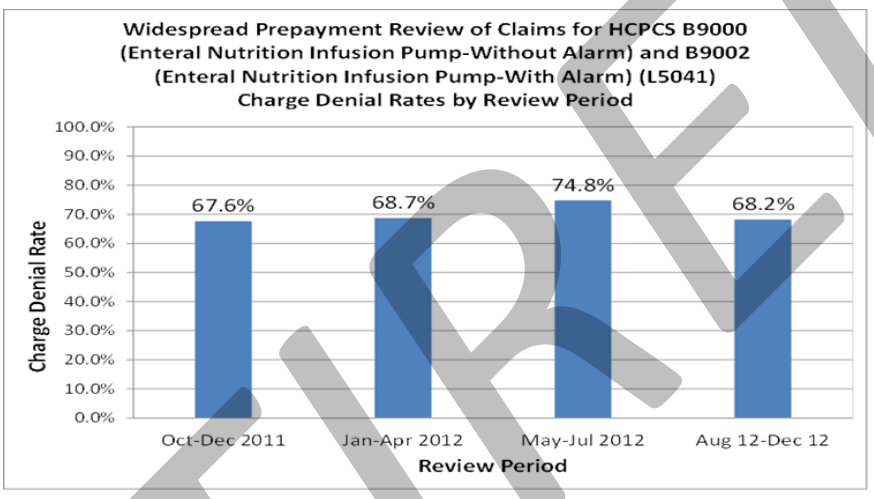
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed May 2012 thru July 2012 and resulted in a 68.7% Charge Denial Rate (CDR).

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm). These findings include claims processed primarily from August 01, 2012 through December 31, 2012.

The review involved prepayment complex medical review of 2284 claims submitted by 300 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 432 (19%) of the claims. For the remaining 1852 claims, 559 claims were allowed and 1293 were denied/partially denied resulting in a claim denial rate of 70%. 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 68.2%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Clinical Documentation Issues

- 8% of the denied claims had *insufficient* clinical documentation to justify the LCD criteria.
  - (a) a permanent non-function or disease of the structures that normally permit food to reach the small bowel (b) a disease of the small bowel which impairs digestion and absorption of an oral diet.
  - **Note:** *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 36% of the denied claims did not have any medical record documentation submitted.

Proof of Delivery

- 17% of the denied claims had no Proof of Delivery
- 3% Incomplete delivery, no signature, no date

Detailed Written Order Issues

- 18% of the denied claims had missing detailed written orders.
- 20% of the denied claims had incomplete detailed written orders.
  - Date of the detailed order was incomplete (missing month or year)
  - Physician's signature could not be authenticated

DME MAC Informational Form (DIF) Discrepancies

- 3% of the denied claims were missing a DIF
- 3% of the denied claims had DIFs that were incomplete

- No Enteral pump listed
- No supplier signature

Claim Examples

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

Example 1:

Received: A detailed written order from the physician and a completed DIF, clinical notes and delivery ticket
Missing: Clinical notes demonstrating that the beneficiary is unable to take in oral nutrition. Missing clinical documentation from physician that supports policy coverage criteria for Enteral Nutrition per LCD L5041

Example 2:

Received: The supplier submitted a valid DIF, clinical notes, detailed physician's order
Missing: Valid proof of delivery

Example 3:

Received: DIF and Delivery ticket
Missing: Illegible physicians signature therefore unable to authenticate physician's signature on detailed order. Clinical notes from physician to support use of Enteral pump.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm).

Educational References

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

- Enteral Nutrition (L5041) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Results of Widespread Prepayment Probe for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (Issued 07/20/2012 and 03/11/2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (Issued 11/09/2012, 05/11/2012, 12/22/2011, and 09/30/2011)
  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 - Enteral Nutrition
  http://www.medicarenhic.com/dme/CERT/EN_phy_letter_doc.pdf
- Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/self-service.shtml
- Frequently Asked Questions (search word Enteral)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Enteral Nutrition Supply Kits - Coverage Reminder
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_enteral-kits.pdf

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

Historical Review Results

DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of the previous review findings. The previous quarterly findings covered claims reviewed from April 2012 through June 2012 and resulted in a 50.9% Charge Denial Rate (CDR).

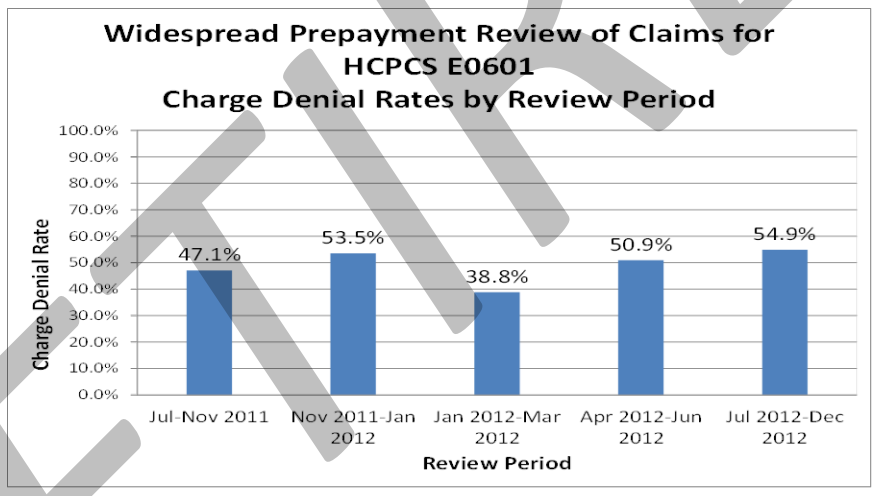
Current Review Results

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 July 2012 through December 2012. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 2,656 claims submitted by 555 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 314 (12%) of the claims. Of the 2,342 claims for which responses were received, 1,382 claims were allowed and 1,274 were denied/partially denied. This resulted in a claim denial rate of 54.3%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 54.9%.

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 noted below reflect the fact that a claim could have more than one missing/incomplete item:

Face to Face Clinical Evaluation Documentation Issues

- 31.5% 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
- 23.2% 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
- 10.3% of the denied claims were missing the physician signature on the Face to Face clinical evaluation.
- Less than 1% of the denied claims had illegible Face to Face documents.

Detailed Written Order Issues

- 1.6% of the denied claims did not include the Detailed Written Order.
- 10.2% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 0.2% of the denied claims had Detailed Written Orders written prior to the sleep study.
- 1.1% of the denied claims had Detailed Written Orders that were not dated by the treating physician.

Sleep Study Documentation Issues

- 16.5% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 0.8% of the denied claims had sleep study documents that did not meet coverage criteria per the PAP LCD.
- 16.4% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 20.0% of the denied claims did not include evidence of training on the PAP device.
- 6.8% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 4.0% of the denied claims were missing billed items on the Proof of Delivery.
- 2.0% of the denied claims were missing Proof of Delivery.
- 1.6% of the denied claims were delivered after the Date of Service.

Claim Examples

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

Example 1:

Received: Included in this claim are a Face to Face clinical evaluation, a Detailed Written Order, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof and Delivery.

Missing: Medicare requires that services provided must be authenticated by the treating practitioner. There was no real or electronic signature found on the Medicare approved Sleep Study by the interpreting practitioner. The Detailed Written Order included in this claim does not list all separately billed items.

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: Medicare requires that services provided must be authenticated by the treating practitioner. There was no real or electronic signature found on the Face to Face clinical evaluation by the treating physician. In instances where the PAP device and supplies are delivered directly by the supplier, the date the beneficiary received the PAP device and supplies must be the Date of Service on the claim. The Date of Delivery for this claim was after the Date of Service.

Example 3:

Received: Included in this claim are a Face to Face clinical evaluation, a Detailed Written order, and evidence of Training on the PAP device.

Missing: No Medicare approved Sleep Study or Proof of Delivery that the beneficiary received the items prescribed by the treating physician were submitted with this claim.

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 11/30/2012, 8/24/2012, 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/CERT/CERT_phy_letter_pap.pdf
- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/articles/050109_certchecklist.pdf
- 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) (MOB)

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from April 01, 2012 through June 30, 2012, and resulted in a 62.3.7% percent Charge Denial Rate (CDR).

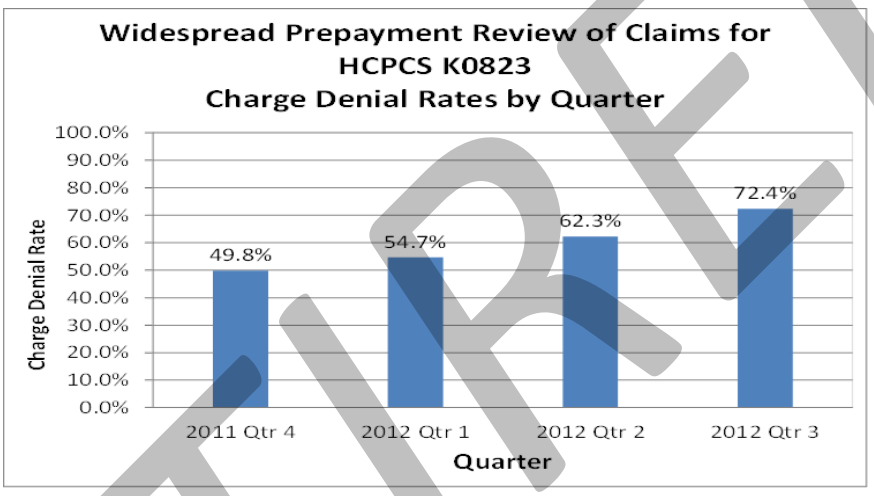
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS code K0823). These findings include claims with dates processed from July 1, 2012 through September 30, 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 543 claims submitted by 203 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 112 (20%) of the ADR requests issued. Of the 431 claims for which responses were received, 87 of the claims were allowed and 344 of the claims were denied. This resulted in a claim denial rate of 79.8%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 72.4%.

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 Clinical Evaluation Documentation Issues

- 35% of the denied claims were missing required clinical documentation and medical records to support medical necessity. These claims did not meet the coverage criteria outlined in the K0823 Local Coverage Determination, L21271.
  - Documentation available from the mobility exam was insufficient and did not include a comprehensive Face to Face Clinical Evaluation by the treating physician that objectively addresses the patient's mobility limitations and provided a clear picture of the patient's mobility deficits. Sufficient objective measurements were also not provided.
  - The Supplier Generated Template provided failed to capture enough comprehensive information and provide additional medical information to demonstrate the reasonable and necessary requirement for the Power Wheelchair requested. No comprehensive narrative clinical documentation was received which reflects a clear understanding of the beneficiary's mobility with measured recordings of patient's upper and lower extremity strength and range of motion.
  - Clinical documentation was insufficient as it did not address historical perspective of the patient's mobility issues and the prior use of other mobility assistive devices.
  - The Face to Face Clinical Evaluation documentation provided did not clearly indicate that the reason for the visit was a mobility evaluation.
- 8% 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.
- 3% 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.
- 3% of the denied claims did not have the treating physician's signature in concurrence with the specialty exam.

7 Element Order Issues

- 2% of the denied claims did not include a 7 Element Order.
- 16% of the denied claims were incomplete, missing one or more of the required elements.
- 7% 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.
- 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.
- 1% of the denied claims had an illegible 7 Element Order.

Detailed Product Description Issues (DPD)

- 10% of the denied claims did not include a Detailed Product Description.
- 7% of the denied claims had an incomplete Detailed Product Description.
- 13% of the denied claims had the Detailed Production Description dated prior to the physician's signature on the 7 Element Order
- 1% 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

- 5% of the denied claims did not include Proof of Delivery.
- 8% of the denied claims had Proof of Delivery that did not match the claim date of service.

LCMP Specialty Exam issues

- 17% of the denied claims did not include financial attestation statement stating the LCMP provider did not have a financial relationship with the supplier providing the wheelchair.

Home Assessment Issues

- 10% 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).
- 6% 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 Specialty Evaluation, the Proof of Delivery, the 7 Element Order, and the Detailed Product Description.

Missing: Home Assessment and Financial Attestation. The documentation provided was missing the Face to Face Clinical Evaluation by ordering physician. The Detailed Product Description did not include the manufacturer name and model number of the specific wheelchair base. Reviewer was unable to determine what type of wheelchair was requested. The date of the Face to Face Clinical Evaluation was incorrect on the 7 Element Order. The date the ordering physician signed the LCMP Specialty Evaluation was not listed as the Face to Face date on the 7 Element Order.

Example 2

Received: Documentation provided in this claim included: the 7 Element Order, the Face to Face Clinical Evaluation by treating physician, and the Detailed Product Description

Missing: Home Assessment and Proof of Delivery. The documentation provided did not include a Home Assessment performed by a supplier representative. Proof of Delivery was not included in the submitted documentation.

Example 3

Received: Documentation provided for this claim included: the 7 Element Order, the Home Assessment, the Proof of Delivery, the Face to Face Clinical Evaluation by treating physician, and the Detailed Product Description.

Missing: Face to Face Clinical Evaluation by treating physician is missing narrative which clearly indicates the major reason for the visit was a mobility examination. The Detailed Product Description did not have a narrative description of the manufacturer name and model name/number of the specific wheelchair base requested in the claim.

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/dmeduc.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_bulletins/mr_bulletin_current/110509_7-element-order.pdf
- Power Mobility Devices Billing Reminder (published 01/11/08)
  http://www.medicarenhic.com/dme/articles/011108_pmd.pdf
- *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 9/28/12, published 07/13/12, published 04/20/12, published 12/15/11, published 08/26/11, published 06/10/11, published 03/11/11, published 11/05/10)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.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

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 April 1, 2012 through June 30, 2012 and resulted in a 36.4% Charge Denial Rate (CDR).

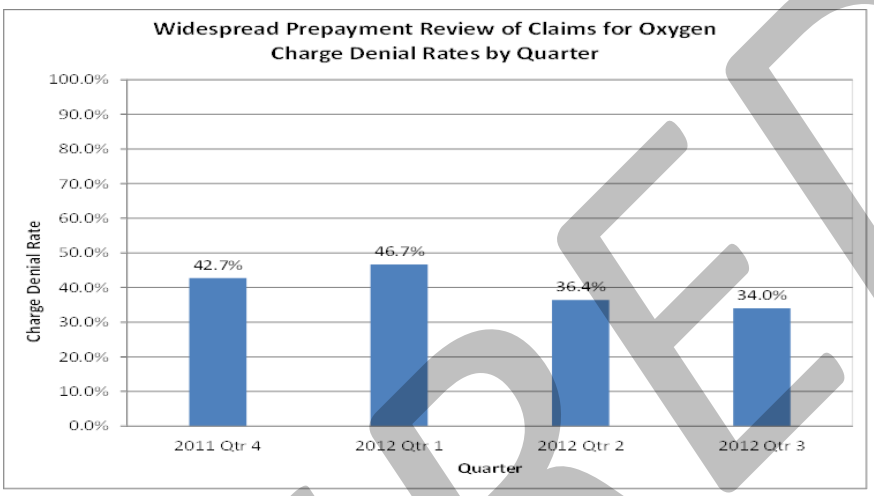
Current Review Results

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 July 1, 2012 through September 30, 2012.

The review involved prepayment complex medical review of 577 claims submitted by 259 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 120 (20%) of the claims. For the remaining 457 claims, 302 claims were allowed and 155 were denied resulting in a claim denial rate of 34%. 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 34%.

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 (88%)

Missing required physician visit per LCD L11468

- 46% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN.
- 3% of the denied claims were missing treating physician visits - 90 days prior to the Recertification CMN. (Initial oxygen).

Missing qualifying blood gas study per LCD L11468

- 20% - No documentation to validate oxygen testing.

Missing required Certificate of Medical Necessity per LCD L11468

- 7% - Missing an Initial CMN.

Missing valid proof of delivery per LCD L11468

- 12% - Missing valid delivery ticket

Clinical Documentation Issues: Medical Necessity could not be established (12%)

Clinical documentation did not support criteria of LCD L11468 for the following reasons (8%)

- No physician clinical notes.
- Physician signature requirement not met
- Documentation illegible, unable to make determination

Clinical documentation did not support criteria indicated on CMN for the following reasons (4%)

- Exercise testing did not qualify for Group 1 testing criteria, documentation did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy
- 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 1 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 3/28/12, code(s) billed: E1390

Documentation received: Written order, valid initial CMN dated 3/28/12, valid delivery ticket, supplier equipment safety checklist, valid results of inpatient oximetry testing dated 3/26/12, patient laboratory results.
Missing: Treating physician visit 30 days prior to initial CMN - Physician progress note is from an outpatient visit dated on 4/3/12, after the date of the initial CMN. A second physician note is provided dated 2/24/09, more than 30 days prior to the date of the initial CMN.

Example 2: DOS 5/11/12, code(s) billed: E1390, E0431

Documentation received: Initial CMN dated 5/11/12, written order, valid delivery ticket, supplier referral/intake form, patient demographic sheet, outpatient physician progress note dated 5/10/12.
Missing: Supporting clinical documentation. Qualifying arterial oxygen saturation is missing. CMN indicates Group 1; however, oxygen saturation provided on CMN does not meet Group 1 criteria.

Example 3: DOS 2/18/12-3/18/12, code(s) billed: E1390, E0431

Documentation received: Written order, valid initial CMN dated 2/18/12, inpatient treating physician note dated 2/17/12, valid delivery ticket.
Missing: Supporting clinical documentation. Missing the qualifying blood gas study, which was obtained closest to, but no earlier than, 2 days prior to the hospital discharge date. Physician note states that patient frequently desaturates and requires oxygen therapy, but no arterial oxygenation testing results are provided to support this.

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/CERT/CERT_phy_letter_oxy.pdf
- 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: October 12, 2012; June 29, 2012; March 2, 2012; November 4, 2011; August 26, 2011; November 5, 2010; and June 9, 2010).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Quiz yourself and your staff.

Visit the *DME MAC A Test Your Knowledge Quizzes* today:
http://www.medicarenhic.com/dme/dme_quiz_index.shtml

HCPCS Code Update - 2013 (GEN)

Date Posted by PDAC 12/17/12

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

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2013.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2013.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2012, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2013.

There is no grace period that would allow submission of the discontinued code for dates of service in 2013.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2013.

The appearance of a code in this list does not necessarily indicate coverage.

External Breast Prostheses

Narrative Changes

Code	Old Narrative	New Narrative
L8000	BREAST PROSTHESIS, MASTECTOMY BRA	BREAST PROSTHESIS, MASTECTOMY BRA, WITHOUT INTEGRATED BREAST PROSTHESIS FORM, ANY SIZE, ANY TYPE
L8001	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, UNILATERAL	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, UNILATERAL, ANY SIZE, ANY TYPE
L8002	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, BILATERAL	BREAST PROSTHESIS, MASTECTOMY BRA, WITH INTEGRATED BREAST PROSTHESIS FORM, BILATERAL, ANY SIZE, ANY TYPE

Hospital Beds and Accessories

Narrative Changes

Code	Old Narrative	New Narrative
E0300	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED	PEDIATRIC CRIB, HOSPITAL GRADE, FULLY ENCLOSED, WITH OR WITHOUT TOP ENCLOSURE

Immunosuppressive Drugs

Discontinued Code

Code	Narrative	Crosswalk to Code
J8561	EVEROLIMUS, ORAL, 0. 25 MG	J7527

Added Code

Code	Narrative
J7527	EVEROLIMUS, ORAL, 0. 25 MG

Impotence Aid

Added Code

Code	Narrative
L7902	TENSION RING, FOR VACUUM ERECTION DEVICE, ANY TYPE, REPLACEMENT ONLY, EACH

Intravenous Immune Globulin

Narrative Changes

Code	Old Narrative	New Narrative
J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX/GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E. G. LIQUID), 500 MG
J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), NON-LYOPHILIZED, (E. G. LIQUID), 500 MG

Lower Limb Prostheses

Added Code

Code	Narrative
L5859	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)

Narrative Changes

Code	Old Narrative	New Narrative
L5972	ALL LOWER EXTREMITY PROSTHESES, FLEXIBLE KEEL FOOT (SAFE, STEN, BOCK DYNAMIC OR EQUAL)	ALL LOWER EXTREMITY PROSTHESES, FOOT, FLEXIBLE KEEL

Ostomy Supplies

Added Code

Code	Narrative
A4435	OSTOMY POUCH, DRAINABLE, HIGH OUTPUT, WITH EXTENDED WEAR BARRIER (ONE-PIECE SYSTEM), WITH OR WITHOUT FILTER, EACH

Oxygen and Oxygen Equipment

Discontinued Code

Code	Narrative	Crosswalk to Code
K0741	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL, INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING, FOR CLUSTER HEADACHES	NONE
K0742	PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT, FOR CLUSTER HEADACHES, FOR INITIAL MONTHS SUPPLY OR TO REPLACE USED CONTENTS	NONE

Pneumatic Compression Devices

Added Code

Code	Narrative
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK

Surgical Dressings

Narrative Changes

Code	Old Narrative	New Narrative
A6021	COLLAGEN DRESSING, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH	COLLAGEN DRESSING, STERILE, SIZE 16 SQ. IN. OR LESS, EACH
A6022	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN. , EACH
A6023	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, SIZE MORE THAN 48 SQ. IN. , EACH

Wheelchair Options/Accessories

Added Code

Code	Narrative
E2378	POWER WHEELCHAIR COMPONENT, ACTUATOR, REPLACEMENT ONLY

Narrative Changes

Code	Old Narrative	New Narrative
E1020	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR	RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR, ANY TYPE
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL MOTOR, REPLACEMENT ONLY
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY	POWER WHEELCHAIR COMPONENT, DRIVE WHEEL GEAR BOX, REPLACEMENT ONLY
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	POWER WHEELCHAIR COMPONENT, INTEGRATED DRIVE WHEEL MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY

HCPCS Code L0430 - Invalid (O&P)

Date Posted by PDAC 01/11/13

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

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

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

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

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

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

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

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

Date Posted by PDAC 02/28/13

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. CMS has requested an additional 30 days to complete its review of the issues involved in classifying these items under the HCPCS. **The new effective end date for all products currently coded under K0009 is April 30, 2013.** Manufacturers that submitted a coding verification application to the PDAC prior to December 3, 2012, will be notified on April 1, 2013 of the coding verification results.

Effective for claims with dates of service on or after May 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/**.

Revised - Power Mobility Device Independent Testing Requirements (MOB)

Published by Palmetto GBA as the SADMERC, December 2007
Republished by NAS as the PDAC, August 2008
Revised by NAS as the PDAC, March 2010
Revised by NAS as the PDAC, February 2013

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

Overview

The Pricing, Data Analysis and Coding (PDAC) contractor is providing this additional information to clarify the Medicare code verification process for Power Mobility Devices (PMDs).

The requirements for safety and performance - testing of PMDs, or power wheelchair models and power operated vehicle (scooter) models, changed effective January 1, 2008.

The PDAC requirements assure Medicare and its beneficiaries have access to verifiable safety and performance test results when selecting an appropriate power wheelchair or scooter to meet their clinical needs. For Medicare, independent testing assures appropriate payment based on quantifiable safety and performance test results for each product model. Safety and performance testing of power wheelchairs and scooters is part of the current Healthcare Common Procedure Coding System (HCPCS) code verification process. The PDAC uses the device test results, device characteristics, power options, patient weight capacity, and seating options to assign products to the PMD HCPCS codes implemented on November 15, 2006.

Independent Testing Requirements

Code verification applications for PMDs that were submitted and completed prior to January 1, 2008, were allowed to have safety and performance testing conducted at manufacturer test facilities.

Code verification applications submitted on/or after January 1, 2008, are required to have Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) tests conducted at a RESNA - capable testing facility. Wheelchairs are classified under HCPCS coding based on the direct results of tests that meet RESNA standards. No other tests or testing standards may be used. If it is found that the testing is not compliant with RESNA standards, the PDAC coding verification application will be rejected. NOTE: The following exception applies:

The drop test and the fatigue test may be conducted at manufacturer testing facilities.

Manufacturer Testing of Power Mobility Devices

Code verification applications submitted to the PDAC must contain thoroughly documented RESNA test data. Test results are subject to review and observation by CMS and its contractors, including requests for additional documentation; such as testing instruments utilized, testing instrument calibration records and/or reports, certification and training qualifications of personnel performing the tests, and the RESNA standards observed.

Manufacturers may continue to perform multi - drum and curb drop fatigue cycle testing as long as the tests are conducted using the latest RESNA protocols, and conducted in a testing facility with equipment and personnel capable of performing the testing in accordance with RESNA standards and parameters. Manufacturers shall continue to provide an attestation from senior management (CEO and/or President or Vice President only) that the manufacturer has performed the PMD testing in accordance with RESNA testing standards. The manufacturer must further certify that the personnel who performed the tests had the training and qualification necessary to be fully knowledgeable of RESNA testing standards, and were capable of conducting the tests in accordance with the required RESNA testing standards. This certification must accompany the code verification request.

Power Mobility Devices Submitted for Independent Testing

For all new PMD models, a full production model PMD available for sale to the public must be submitted to an independent testing facility.

PMD prototypes, customized models, pre - production models and any other design phase type models are not acceptable for Medicare safety and performance testing, nor may any of these be furnished to Medicare beneficiaries.

All new PMD models are required to be tested according to the latest RESNA methods, formulae, and protocols. The latest RESNA test procedures are : RESNA WC - 1:2009 - RESNA American National Standard for Wheelchairs - Volume 1: Requirements and Test Methods for Wheelchairs (Including Scooters) and RESNA WC - 2:2009 - RESNA American National Standard for Wheelchairs - Volume 2: Additional Requirements for Wheelchairs (Including Scooters) with Electrical Systems.

All PMDs must be tested at the maximum patient weight capacity for the base. RESNA has defined the chair configuration for testing and clarified test protocols. All parameters and technical information needed to conduct the testing may be obtained from RESNA at **http://www.resna.org**

Medicare does not specifically endorse the following testing facilities, however the facilities below are identified on the RESNA website as being RESNA capable Powered Mobility Device testing facilities:

University of Pittsburgh
School of Health and Rehabilitation Sciences
Department of Rehabilitation Sciences and Technology
4020 Forbes Tower
Pittsburgh, PA 15260
Phone: 412.383.6558
http://www.shrs.pitt.edu/

Ammer Consulting
1050 Saxonburg Blvd.
Glenshaw, PA 15116
Phone: 412.389.4429
bill@ammerconsulting.com
http://ammerconsulting.com/_wsn/page3.html

Beneficial Designs Inc
PO Box 69
Minden, NV 89423
Phone: 775.783.8822
http://beneficialdesigns.com/

Supplemental PMD Safety and Performance Testing Information

The following RESNA test protocols are listed for your convenience. The bolded and underlined titles represent the subsections required to be tested and results that must be submitted to the PDAC. Some RESNA test sections that are not required are listed for reference in the test protocols for the purposes of clarity. Other RESNA test sections are listed only for convenience. The protocol documents to be used are always the most recent RESNA standards. The manufacturer may perform only Section 8, Tests 10.4(Multi - Drum) and 10.5(Curb Drop) from Volume 1. All other tests are to be performed by an independent test facility. Each test report must contain a photograph of each configuration of the wheelchair during testing and minimum of one photograph of each test setup. The test report shall also include a list of equipment used.(meters, gauges, measuring instruments). Calibration data for all equipment must also be supplied.

Copies of the Resna Standards may be ordered from:
RESNA
1700 N. Moore St., Suite 1540, Arlington, VA 22209 - 1903
PHONE: 703/524 - 6686 FAX: 703/524 - 6630 TTY: 703/524 - 6639
WEB SITE: **http://www.resna.org** EMAIL: **publications@resna.org**

Volume 1: Requirements and Test Methods for Wheelchairs (including POVs)

Section 1: Determination of Static Stability

Static Stability of Chairs with Power Options:

Section 1 - 10.3: Rearward Stability with wheels locked (If there are non-locking casters to the rear, use 10.2 Rearward Stability with wheels unlocked)

Section 1 - 11.2: Rearward Anti - tip stability with wheels locked (could be rearward, forward, or both depending on where the anti - tip devices are placed)

Section 5: Determination of Dimensions, Mass and Maneuvering Space

Length - Section 5 - 8.2 - Full overall length - including a foot space gauge on the foot supports. The new test procedure includes feet on the chair to simulate the space required by user with feet on the foot supports. Record and disclose the length with and without the foot space gauge.

Width - Section 5 - 8.3 - Full overall width

Pivot Width - Section 5 - 8.11 - Pivot width - this is the turning radius for a power wheelchair with joystick steering.

Reversing Width - Section 5 - 8.12 - This is a three - point turn and applies to a POV with tiller steering.

Corridor Turn test - Section 5 - 8.15 - Width of angled corridor required to determine the minimum width of hallway needed for the device to turn around.

Section 7: Method of Measurement of Seating and Wheel Dimensions Seating Measurements for Coding - Section 7

7.3.2 Seat Plane Angle
7.3.3 Effective Seat Depth
7.3.4 Seat Width
7.3.6 Seat Surface Height at Front Edge
7.3.7 Back Support Angle
7.3.8 Back Support Height

Section 8: Requirements and Test Methods for Static, Impact and Fatigue Strengths

Fatigue Test on Level with Slats - Section 8:
10.4 Multi - Drum Test
Drop Cycles - Section 8:
10.5 Drop Test

Section 11: Test Dummies

Section 13: Determination of Coefficient of Friction of Test Surfaces

Section 15: Requirements for Information Disclosure, Documentation and Labeling

Section 16: Resistance to Ignition of Upholstered Parts - Requirements and Test Methods

Section 19: Requirements and test Methods for Wheelchairs (including POVs): Wheelchairs Used as Seats in Motor Vehicles (selected models only)

Section 20: Determination of the Performance of Stand - Up Type Wheelchairs

Section 22: Set Up Procedures

Section 26: Vocabulary

Volume 2: Additional Requirements for Wheelchairs (including POVs) with Electrical Systems

Section 2: Determination of Dynamic Stability of Electric Wheelchairs

Dynamic Stability Incline

Section 2 - Driving Tests on Slopes and Level - Maximum slope the chair passes all tests with a score of 2 or better.

Clause 8 Tests for rearward dynamic stability - 3 tests -

8.2 Starting forwards
8.3 Stopping after traveling forwards
8.4 Braking when traveling backwards

Clause 9 - Tests for forward dynamic stability - 2 tests -

9.2 Braking when traveling forwards
9.3 Traveling forward down a slope onto a horizontal surface

Clause 10 - Tests for dynamic stability in lateral directions - 2 tests -

10.2 Turning on a slope
10.3 Turning in a circle at maximum speed (applies only to POVs) Disclosure
10.4 Turning suddenly at maximum speed (applies to PMD with joystick steering)

Section 2 - Step Transition Tests - Maximum step transition height that chair can pass all related stability tests with a score of 2 or better.

Clause 8 Tests for rearward dynamic stability - 2 tests -

8.5 Traveling forward up a step transition from a standing start,
8.6 Traveling backward down a step transition from a standing start

Clause 9 - Tests for forward dynamic stability - 2 tests -

9.4 Traveling forward up a step transition at maximum speed,
9.5 Traveling forward down a step transition from a standing start

Clause 10 - Tests for dynamic stability in lateral directions - 1 test

10.5 One side of the wheelchair drops down a step transition

Section 3: Determination of Effectiveness of Brakes

Section 4: Energy Consumption of Electric Wheelchairs and POVs for Determination of Theoretical Distance Range

Theoretical Driving Range - Section 4 - 7.1 - this test calculates the maximum distance potentially available on a fully charged battery under ideal conditions.

Theoretical Maneuvering Range - Section 4 - 7.2 Maneuvering test - this test simulates range of the device when required to turn.

Section 6: Determination of Maximum Speed, Acceleration and Deceleration of Electric Wheelchairs

Minimum Top End Speed - Flat - Section 6 - 6.1 Determination of Maximum speed on a horizontal surface

Maximum Top End Speed On Slope - Section 6 - 6.5 Maximum speed on a slope. Testing is done on the same slope used for the dynamic stability slope.

Section 9: Climatic Tests for Electric Wheelchairs

Section 10: Determination of Obstacle - Climbing Ability of Electrically Powered Wheelchairs

Obstacle Height - Section 10 - Clause 7 - Maximum obstacle height to ascend and descend with technique described.

Section 14: Power and Control Systems for Electric Wheelchairs - Requirements and Test Method

Maximum Thermal Drive Test - Section 14 - 6.18 Maximum Thermal Drive - Test discloses maximum driving time and driving distance uphill

Maximum Power Stall Condition - Section 14 - 6.14 Stalled Condition Protection - This test ensures that the device has protection at the controller for the motors if someone tries to drive when stuck.

Section 21: Requirements and Test Methods for Electromagnetic Compatibility of Electrically Powered Wheelchairs and Motorized POVs

Revised - Coding Guidelines For Ankle Foot Orthoses (O&P)

Date Posted by PDAC 02/07/13

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

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

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

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

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

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

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

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

Revised - Collagen Surgical Dressings - Coding Verification Review Requirement (SPE)

Date Posted by PDAC 02/25/13

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

Questions have recently come to the attention of the DME MACs and the PDAC concerning collagen dressings. The Local Coverage Determination Policy and Policy Article for Surgical Dressings contain the coverage criteria for surgical dressings as well as the Coding Guidelines for Surgical Dressings. The Surgical Dressings Policy Article states: *Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multi-component products may not be unbundled and billed as the separate components of the dressing.*

In the case of collagen dressings coded A6021, A6022, A6023 and A6024, the predominate component must be collagen.

Effective for claims with dates of service on or after June 1, 2013, the only products which may be billed to Medicare using code A6021, A6022, A6023 and A6024 are those for which a written coding verification has been made by the PDAC contractor and are listed on the Product Classification List in the Durable Medical Equipment Coding System (DMECS) maintained on the PDAC web site, **https://www.dmepdac.com/dmecsapp/do/search**. The DME MACs will be updating the Surgical Dressing Local Coverage Determination and Policy Article with this information.

All products currently listed on the Pricing, Data Analysis, and Coding (PDAC) contractor web site with HCPCS codes A6021, A6022, A6023 and A6024 will be end dated effective June 1, 2013, with the exception of the predicate product and a product recently reviewed by CMS' Alpha Numeric Workgroup. Manufacturers will be required to submit a new coding verification application to the PDAC for review and assignment of the correct code for products currently coded as A6021, A6022, A6023 and A6024.

Products which have not received coding verification review from the PDAC must be billed with code A9270.

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

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

Fourth Quarter 2012 - 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 October through December 2012 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	125,102	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.116.2000B.SBR04.007 Entity's Group Name. Information submitted inconsistent with billing guidelines	62,345	Subscriber Group Name (SBR04) should not be present in the 2000B (Medicare Insurance Information) loop.
X222.116.2000B.SBR09.010 Information submitted inconsistent with billing guidelines. Entity's claim filing indicator.	32,056	Claim Filing Indicator Code must be "MB. This indicator indicates Medicare Part B. The DME Medicare insurance will use the "MB" Claim Filing Indicator Code.
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	29,202	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	21,541	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	15,891	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
X222.157.2300.CLM02.090 This Claim is rejected for Invalid Information on an MSP claim	15,798	The total claim level and line level adjustment amounts plus the primary paid amount must equal the total for all submitted charges.
X222.087.2010AA.NM109.030 Invalid information in the Billing Provider's NPI	15,096	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.226.2300.HI01-2.030 Invalid Information within the Primary diagnosis code	13,815	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.380.2400.DTP03.080 Invalid Information within the Future date and Date(s) of service	13,492	The service start/from date is greater than the date this claim was received.

Fourth Quarter 2012 - 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 fourth quarter of 2012. 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 October through December 2012.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	32,385
CO 16 MA140 Patient/Insured Health Identification number and name do not match.	**Item 1A** The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.	17,732
OA109, N104 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	12,368
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.	12,176
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).	3,385
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.	3,007
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.	2,183
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.	1,889
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.	1,780
CO 16 M51, N225, N29 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	1,104

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.

Hurricane Sandy Ask-the-Contractor (ACT) Teleconference Q&A November 9, 2012 (GEN)

Q: **Which place of service should we bill if the patient is in temporary lodging?**
A: If a patient is displaced because of the Hurricane and they are staying in a hotel, etc., you would bill place of service 16 (16 - Temporary Lodging - A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code).

Q: **If a patient is displaced and moves from New Jersey to Pennsylvania, and a supplier needs to deliver a new hospital bed because they cannot access the patient's home to retrieve the original bed, is there any compensation for the provider to transport the new bed to the second site?**
A: *Claims Processing Manual* Chapter 20, Section 60 has information about delivery charges and the allowance for unusual circumstances. Reference to *Claims Processing Manual*, Chapter 20 at: **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c20.pdf**

Q: **We have several patients that have been discharged from a SNF back to their home. How will providers know if a patient has been discharged from a SNF?**
A: The suppliers should verify any skilled nursing facility stays through the IVR or check with the beneficiary.

Q: **If a patient has a piece of capped rental equipment that has not met the purchase price and has been lost in a storm surge, and we are able to replace that equipment with the CR modifier. What happens with the original piece of equipment where only 2 months were paid? Am I going to get reimbursed for the remaining 11 months?**
A: The supplier should check with their insurance to confirm if the item is covered.

Q: **If a patient lives in Texas but travels with their CPAP machine to the area affected by Hurricane Sandy, the equipment was lost in the storm, are they eligible to get the equipment replaced?**
A: Yes. The beneficiary was located in the disaster when the CPAP was lost. Refer to the "DMEPOS Repair and Replacement Caused by Hurricane Sandy and CR Modifier Update - November 2012" article that was recently published for further instructions on our web site at: **http://www.medicarenhic.com/dme/articles/111612_sandy_cr.pdf**

Q: **Due to the CPAP being lost in the storm, we are unable to obtain the download for compliance. Is this something that will be waived?**
A: In general, Medicare coverage or payment rules cannot be waived, even in a disaster or emergency. Refer to CMS Q&A #1135-B1 at: **http://www.cms.gov/About-CMS/Agency-Information/Emergency/downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf**. This link was included in the "*Frequently Asked Questions (FAQs) and Ask-the-Contractor (ACT) Teleconference*" posted under Hurricane Sandy Updates section at: **http://www.medicarenhic.com/dme/sandy.shtml**

Q: **Would claims with a CR modifier be less stringent?**
A: The CR modifier is only informational. The same process regarding proper documentation and correct claim submission will still be required.

Q: **If a "snow bird" patient lost their equipment in the storm but then traveled to Florida, how would the provider in Florida process the claim?**

A: The supplier in Florida can submit the claim with the CR modifier and bill for replacement equipment. All other applicable modifiers must also be appended. Refer to the "*DMEPOS Repair and Replacement Caused by Hurricane Sandy and CR Modifier Update - November 2012*" article posted on our web site at: **http://www.medicarenhic.com/dme/articles/111612_sandy_cr.pdf**

Q: **If we need to replace a hospital bed due to the hurricane, do we use the CR modifier in conjunction with the RA modifier?**

A: Yes. An example would be E0260RRKHKXRACR, If there are more than four modifiers attached, as in this example, you need to replace the fourth modifier with 99 or KB (upgrades only) and enter the remaining modifiers in Item 19 of paper claims or the NTE 2300 or NTE2400 fields of electronic claims

Q: **How do we handle issues of a patient not being able to get their full therapy on a CPM device due to power outages?**

A: The claim can be sent through the appeals process if there is documentation to support the therapeutic value of extending therapy.

Q: **The original supplier cannot provide contents to the patient; therefore, they are contacting new suppliers for the contents. What happens in this scenario?**

A: Payment rules for oxygen are unchanged. The original supplier is responsible to provide or arrange to have provided whatever is needed. If you furnished liquid or gaseous oxygen equipment during the 36-month rental period, you are responsible for furnishing the oxygen contents used with the oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparably damaged).

Q: **Is there any additional reimbursement for contents due to these circumstances?**

A: No, The reimbursement rate for contents remains the same.

Q: **Is Medicare going to waive the 14 day payment floor?**

A: No. Medicare coverage or payment rules cannot be waived, even in a disaster or emergency.

Q: **If the patient is admitted into a facility (hospital, SNF) due to flooding will the supplier be paid for equipment?**

A: The payment rules for DME have not changed. DME is not separately payable in a Hospital or Nursing Facility.

Q: **What type of documentation is required to prove the patient lost the equipment in the hurricane?**

A: A statement from the patient is acceptable.

Q: **Will a new order and/or CMN be required prior to replacing the equipment?**

A: It's required prior to billing not prior to delivery except for the items that require a written order prior to delivery (WOPD).

Q: **Some equipment has been flooded out, and people left their houses and lost CPAP masks, nebulizer kits, etc. Replacement is occurring sooner than what is eligible per the LCD. Is Medicare going to waive this requirement?**

A: Yes. This would fall under the replacement rules for non-consumable supplies. Since the replacement is due to loss or irreparable damage, new supplies would be allowed.

Q: **A lot of patients had to flee their homes between Sunday and Monday, we instructed patients to head to the nearest hospital. The hospitals didn't admit the patients "per say" but they admitted the patients with the suppliers equipment to plug in for power. Are suppliers going to be reimbursed for that month?**

A: The payment rules for DME have not changed. If the patient was not admitted to the hospital, the payment would not be interrupted during the reporting month for the equipment.

Q: **What guidance is there for providers, physicians, and hospitals that have lost all records?**
A: Refer to the article "*DME MAC Review (Audit) Related Administrative Relief Specific to Hurricane Sandy Damaged Areas*" posted on our web site regarding this topic at: **http://www.medicarenhic.com/dme/articles/111612_Sandy-003.pdf**. You may also want to refer to the CERT letter that is also posted on our web site at: **http://www.medicarenhic.com/dme/sandy.shtml**

Q: **In reference to the PMD Demo - is there any information on how to handle patients that need replacement equipment? Will they be required to have a prior authorization?**
A: NHIC has received clarification from CMS. Providers do not need to go through prior authorization for a replacement PMD due to catastrophic loss during the 5 years useful lifetime period. All other DME MAC instructions for submitting a claim associated with a replacement should be followed. In addition, providers are not subject to the 25% reduction for replacement PMD's, due to Hurricane Sandy they do not have to go through the Prior Authorization Request (PAR).

Q: **For the patients that do need their equipment replaced, we are unable to locate their physicians to obtain the Detailed Written Order. How are these claims to be submitted?**
A: Please refer to the "*DMEPOS Repair and Replacement Caused by Hurricane Sandy and CR Modifier Update - November 2012*" article posted on our web site at: **http://www.medicarenhic.com/dme/articles/111612_sandy_cr.pdf**

Q: **Is the CR modifier attached to the beneficiary's zip code and not the supplier's zip code?**
A: No. The CR modifier is not specific to certain zip codes. The CR modifier should be appended to all HCPCS for the equipment/supplies affected by Hurricane Sandy. All other applicable modifiers must also be appended. Please refer to the "*DMEPOS Repair and Replacement Caused by Hurricane Sandy and CR Modifier Update - November 2012*" article posted on our web site at: **http://www.medicarenhic.com/dme/articles/111612_sandy_cr.pdf**

Hurricane Sandy Ask-the-Contractor (ACT) Teleconference Q&A November 20, 2012 (GEN)

Q1: **We understand that there is no process in place for waivers on CPAP trials. Many beneficiaries are not going to be compliant due to power outages. Are patients required to have a new sleep study at this point if they are not compliant?**
A1: An FAQ for PAP devices published on May 18, 2012, question #13 allows for the suspension of the trial period during a hospitalization or skilled nursing facility (SNF) stay. Based upon this principle, allowing an extension of the trial period until power is restored and the beneficiary is able to resume use of their PAP equipment is reasonable. Although no specific documentation requirements are stated in the policy regarding this scenario, we encourage suppliers to make a note regarding the duration of the power outage. **http://www.medicarenhic.com/dme/articles/111612_Sandy-001.pdf**

Q2: **At this point are we still required to obtain a police report for lost or damaged equipment from Hurricane Sandy?**
A2: It was suggested for beneficiaries to obtain a police report; however, suppliers could note in the patient's records that the equipment was lost or damaged from Hurricane Sandy. Please refer to the *DMEPOS Repair and Replacement Caused by Hurricane Sandy and CR Modifier Update - November 2012* (**http://www.medicarenhic.com/dme/articles/111612_sandy_cr.pdf**) article that was posted to our web site on 11/16/2012.

Q3: **All of the counties of New Jersey have been updated on the governor's web site. Are they all a part of the affected Hurricane areas?**
A3: **Curre**ntly, a daily status report is sent to CMS. This question was addressed and we are awaiting CMS clarification. As we understand it, only the counties that are still listed on FEMA's web site are the counties that were listed in the article that was published on our web site at: **http://www.medicarenhic.com/dme/articles/111612_Sandy-001.pdf**

Q4: **Now that the web site has been updated, what should we do if a patient resides in one of those updated counties?**
A4: **We are awaiting clarification** on this from CMS.

Q5: **How do we know if we need to apply for the 1135 waiver?**
A5: Please refer to the following links regarding the CMS Q&A's with and without an 1135 waiver.
http://www.cms.gov/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf
http://www.cms.gov/Emergency/downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf

Q6: **Is the face to face requirement waived in the case of a natural disaster for replacement of a PMD? The supplier has beneficiaries who have lost their equipment. The supplier stated they are able to get a prescription from the doctor, but the beneficiary has no way of getting to the doctor because they are in a Red Cross shelter. Does the patient need a face to face in order for the PMD to be replaced?**
A6: A face to face is not required for power wheelchairs as long as you are replacing it with an item in the same performance group and the replacement is due to a natural disaster.

Q7: **Will there be a formal communication process on the prior approval process being suspended for replacement items on the PMD demonstration?**
A7: Please refer to the *Reduction in Payment for Power Mobility Devices* (**http://www.medicarenhic.com/dme/articles/112112_PMD.pdf**) article that was posted to our web site on 11/21/2012.

Q8: **If there is a wheelchair that is renting on the fourth month and the equipment was destroyed in the hurricane would a new capped rental item be considered?**
A8: If a beneficiary resides in the disaster area of Hurricane Sandy, then yes a new capped rental item would be considered. Please refer to the *DMEPOS Repair and Replacement Caused by Hurricane Sandy and CR Modifier Update - November 2012* (**http://www.medicarenhic.com/dme/articles/111612_sandy_cr.pdf**) article that was posted to our web site on 11/16/2012.

Q9: **Would the replacement wheelchair rental start over as the first month for billing?**
A9: Yes, a new capped rental for 13 months would begin for replacement of the wheelchair.

Q10: **If the oxygen has been renting for 24 months and the equipment was destroyed in the Hurricane, once we replace the equipment do we start a new capped rental period back to month one?**
A10: Yes, a new 36 month rental would begin for oxygen replacement.

Q11: **If the beneficiary did not want the equipment again, are we out the equipment because it was lost in the flood, even though we were only paid for three months of rental on the equipment?**
A11: We will post this as a follow-up. We are awaiting clarification.

Q12: **A follow-up question was asked about oxygen regarding the replacement of a new capped period if the concentrator was destroyed. The supplied asked if a new face to face would be required because this would fall under continuation of care.**
A12: In this circumstance a new test or CMN would not be required. Please refer to the Oxygen LCD. For additional information refer to **http://www.medicarenhic.com/dme/articles/111612_Sandy-001.pdf**

Additions to Lower Limb Prosthesis - Billing Reminder (O&P)

When providing additions to a lower limb prosthesis, the determination of medical necessity for certain components/additions is based on the beneficiary's potential functional abilities.

Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

- The beneficiary's past history (including prior prosthetic use if applicable); and
- The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
- The beneficiary's desire to ambulate.

Clinical assessments of beneficiary's rehabilitation potential must be based on the classification levels listed in the Local Coverage Determination (LCD) for Lower Limb Prostheses.

For example:

- An external keel SACH foot (L5970) or single axis ankle/foot (L5974) is covered for beneficiaries whose functional level is 1 or above.
- A flexible-keel foot (L5972) or multiaxial ankle/foot (L5978) is covered for beneficiaries whose functional level is 2 or above.
- A microprocessor controlled ankle foot system (L5973), energy storing foot (L5976), dynamic response foot with multi-axial ankle (L5979), flex foot system (L5980), flex-walk system or equal (L5981), or shank foot system with vertical loading pylon (L5987) are covered for beneficiaries whose functional level is 3 or above.

Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot. This information must be retained in the physician's or prosthetist's files.

If a prosthesis is denied as not reasonable and necessary, related additions will also be denied as not reasonable and necessary.

Skilled Nursing Facility (SNF) Consolidated Billing - Reminder (GEN)

Under Consolidated Billing, a Skilled Nursing Facility (SNF) itself must submit all Medicare claims for the services that its residents receive during a covered Part A stay, except for specifically excluded services that are outside the Prospective Payment System (PPS) bundle and are separately billable under Part B when furnished to the SNF's resident by an outside supplier.

For a list of items that are separately payable during a Part A covered stay, please refer to the Consolidated Billing List File 1 on the CMS web site at: **http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2013Update.html**

Additional information is also available in:

- The Skilled Nursing Facility Prospective Payment System Fact Sheet
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/snfprospaymtfctsht.pdf
- Skilled Nursing Facility and Consolidated Billing Tutorial
  http://www.medicarenhic.com/dme/dme-eduonline.shtml#tutorials

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Going Green - An Electronic Environment (GEN)

NHIC, Corp. DME MAC A would like to remind suppliers of the importance of "Going Green" and the benefits of an electronic environment as a result of submitting electronic claims, receiving Electronic Remittance Advices (ERAs), using Medicare Remit Easy Print (MREP), and enrolling in Electronic Funds Transfers (EFTs).

Electronic Funds Transfer (EFT)

With EFT, Medicare will send payments directly to a supplier's financial institution. All Medicare suppliers may apply for EFT.

There are many benefits of EFT including:

- Reduction of the amount of paper in the office
- Valuable time savings for staff and avoidance of hassle associated with going to the bank to deposit Medicare check
- Elimination of the risk of Medicare paper checks being lost or stolen in the mail
- Faster access to funds; many banks credit direct deposits faster than paper checks
- Easier reconciliation of payments with bank statements

For further information and to enroll in EFT refer to the Electronic Funds Transfer section of the NHIC, Corp DME MAC A Web site at **http://www.medicarenhic.com/dme/dme_eft.shtml**

Electronic Remittance Advice (ERA)

Another benefit of electronic billing is the electronic remittance advice (ERA). An ERA is an outbound electronic data interchange (EDI) transaction that enables you to receive payment information in an electronic file format. If you have software capability in place in your system, an ERA file created by Medicare can be automatically posted to your accounts receivable system. Once the ERA is in place, the payment posting process is more efficient and accurate.

Additional benefits of ERA include:

- Faster communication and payment
- Faster account reconciliation
- Improves office productivity
- Automation of follow-up action
- Paperwork reduction, and
- Detailed information

To sign up for ERAs, suppliers will need to complete the appropriate enrollment form (**http://www.ngscedi.com/forms/formsindex.htm#1**) and submit it to the CEDI Contractor. You will want to select the 835 transaction option to sign up for ERAs.

For further information on the Remittance Advice refer to the "*Understanding the Remittance Advice for Professional Providers*" web-based training on the Centers for Medicare & Medicaid Services (CMS) Web site by visiting **http://cms.meridianksi.com** and then clicking on the "web-based training courses" link, or by reviewing the *DME MAC A Interactive Remittance Advice* (**http://www.medicarenhic.com/dme/online/Interactive_RA.pdf**) on the DME MAC A Web site.

Benefits of Electronic Claims

Medicare claims submitted electronically, via Electronic Data Interchange (EDI), have the benefits of being filed faster, more efficiently, and more cost-effectively than paper claims. Suppliers who do not bill claims electronically should consider the following advantages of EDI:

- 14-day payment floor versus 29-day payment floor for paper claims
- Increased accuracy and minimized rejections - direct processing (processors do not re-key claims)
- Online claim status verification/eligibility
- Ability to submit claims seven days a week, including holidays (excluding system maintenance)
- A contractor dedicated solely for EDI support for faster problem resolution
- Free software: **http://www.ngscedi.com/downloads/Downloadindex.htm#1**

Electronic billing is available to both participating and non-participating suppliers as well as accepting assigned and non-assigned claims.

Medicare Remit Easy Print (MREP) Software

Save TIME and MONEY by taking advantage of FREE MREP software available for viewing and printing the ERA!
The MREP software gives providers and suppliers the following abilities:

- Easy navigation and viewing of the ERA using your personal computer
- Print the ERA in the SPR format
- Search capability that allows providers and suppliers the ability to find claims information easily
- Print and export reports about ERAs including denied, adjusted, and deductible applied claims
- Easy-to-use method to archive, restore, and delete imported ERAs

Providers and suppliers can view and print as many or as few claims as needed. This FREE software can save you time resolving Medicare claim issues. Take advantage of the MREP features unavailable with the SPR. Get started today!

For further information and to download MREP software refer to the Medicare Remit Easy Print section of the CMS Web site at:

http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html

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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.

Supplier Manual News (GEN)

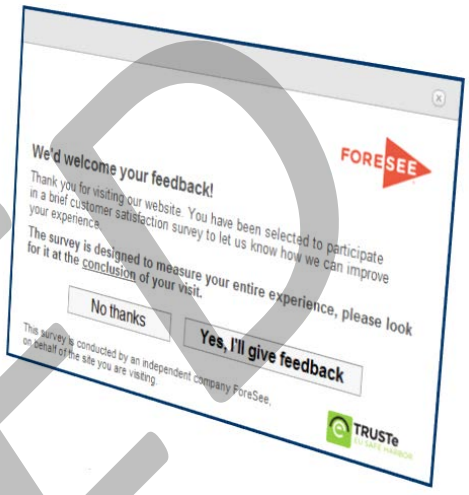
The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) *Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/dme_publications.shtml**. After accepting the CPT License Agreement, suppliers can access the 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 December of 2012 chapters 1, 2, 3, 4, 10, and 12 of the *DME MAC A Supplier Manual* were 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.

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey

NHIC, Corp. DME MAC Jurisdiction A is committed to ensuring that our Web site meets the needs of our users. We continually strive to improve our offerings based on the information and feedback we receive from you. In order to accomplish this, we offer *The DME MAC A Web site Customer Satisfaction Survey*. This survey is designed to collect information that helps measure providers' satisfaction with contractors' Web sites with a focus on customer service.



If you see the **Customer Satisfaction Survey** pop up while you are browsing the DME MAC A Web site, please take a moment to participate. Completion should only take a few minutes.

As our site is constantly changing, we would appreciate your input! We are listening... It is **your** feedback that makes those changes possible!

Thank you for taking the time to provide us with your comments! Remember, it is your feedback that makes changes possible in order to address your Medicare needs!

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

Hurricane Sandy

For information regarding the impact of the storm visit the Hurricane Sandy Highlights and Headlines section of our Web site.

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

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

March 2013
Number 27

Publication Information

NHIC, Corp. is the contractor for the Jurisdiction A DME MAC serving all of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Visit the following websites for more information:

NHIC, Corp.: www.medicarenhic.com/dme

TriCenturion: www.tricenturion.com

CMS: www.cms.gov

The *DME MAC Jurisdiction A Resource*, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

DME MAC Jurisdiction A Resource Coordinator
Outreach & Education Publications
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
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