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:
**http://www.medicarenhic.com/dme/**

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# Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2014 (MM8676) (GEN)

**MLN Matters® Number: MM8676 Revised**
**Related CR Release Date: May 23, 2014**
**Related CR Transmittal #: R2968CP**
**Related Change Request (CR) #: CR 8676**
**Effective Date: October 1, 2014**
**Implementation Date: October 6, 2014**

**Note:** *This article was revised on October 16, 2014, to reference the correct HCPCS codes and to add a link to the Quarterly Update pages of the competitive bidding website in the "What You Need to Know" section. All other information remains the same.*

## Provider Types Affected

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

## What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8676 to provide the DMEPOS Competitive Bidding Program (CBP) October 2014 quarterly update. CR 8676 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are also posted to **http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home** on the Internet. At that site, click on the quarterly updates link in the left of the page.

### *ZIP Codes (Round 2 Only)*

The following ZIP codes have been added to the Round 2 ZIP code files listed below to conform with U.S. Postal Service ZIP code changes within the identified competitive bidding areas:

- 97003 Portland-Vancouver-Beaverton, OR-WA
- 97078 Portland-Vancouver-Beaverton, OR-WA
- 20252 Washington-Arlington-Alexandria, DC-VA-MD-WV
- 56988 Washington-Arlington-Alexandria, DC-VA-MD-WV

The ZIP code files can be used to identify when a specific item furnished to a beneficiary is subject to the Competitive Bidding Program.

### *HCPCS Codes (Round 1 Recompete Only)*

Effective January 1, 2014, the Round 1 Recompete Single Payment Amount file has been updated to replace HCPCS code, E0731NU, with HCPCS code, E0731NUKG. This change allows Medicare to accurately process and pay HCPCS code E0731 (Form Fitting Conductive Garment for Delivery of TENS or NMES (with Conductive Fibers Separated from the Patient's Skin by Layers of Fabric)) according to competitive bidding payment rules when used in conjunction with a competitive bidding base unit, such as a TENS device.

## Background

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

The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, the result being reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

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

MIPPA also delayed the competition for Round Two from 2009 to 2011 and authorized national mail order competitions after 2010. The *Affordable Care Act of 2010* expanded the number of Round Two MSAs from 70 to 91 and specified that all areas of the country be subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The contracts and prices for Round 2 and the national mail-order program for diabetic testing supplies became effective on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except mail-order diabetic supplies expired on December 31, 2013. (The Round One Rebid mail-order diabetic supply contracts expired on December 31, 2012.) On January 1, 2014, new contracts for the Round One Recompete became effective in the same competitive bidding areas as the Round One Rebid.

### Additional Information

The official instruction, CR 8676 issued to your DME MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2968CP.pdf** on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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## Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2015 (MM8907) (GEN)

**MLN Matters® Number: MM8907**
**Related CR Release Date: September 12, 2014**
**Related CR Transmittal #: R3068CP**

**Related Change Request (CR) #: CR 8907**
**Effective Date: January 1, 2015**
**Implementation Date: January 5, 2015**

### Provider Types Affected

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

### What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8907 to provide the DMEPOS Competitive Bidding Program (CBP) January 2015 quarterly update. Change Request (CR) 8907 provides specific instructions for the DME MACs in implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

### Background

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

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

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

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

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

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

### Additional Information

The official instruction for CR 8907 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3068CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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## Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2015 (MM8918) (GEN)

**MLN Matters® Number: MM8918**
**Related CR Release Date: November 26, 2014**
**Related CR Transmittal #: R3136CP**

**Related Change Request (CR) #: CR 8918**
**Effective Date: April 1, 2015**
**Implementation Date: April 6, 2015**

### Provider Types Affected

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

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8918 to provide the DMEPOS Competitive Bidding Program (CBP) April 2015 quarterly update. CR 8918 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

### Background

The DMEPOS Competitive Bidding Program was mandated by Congress through the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

Under the program, a competition among suppliers who operate in a particular competitive bidding area is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

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

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

## Additional Information

The official instruction, CR 8918 issued to your DME MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3136CP.pdf** on the CMS website.

There are 14 separate products on pages four through six in the MLN Catalogue of Products at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/mlncatalog.pdf** that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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# October Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (GEN)

**MLN Matters® Number: MM8865 Revised**
**Related CR Release Date: November 13, 2014**
**Related CR Transmittal #: R3123CP**

**Related Change Request (CR) #: CR 8865**
**Effective Date: October 1, 2014**
**Implementation Date: October 6, 2014**

**Note:** *This article was revised on November 17, 2014, to reflect the revised CR8865 issued on November 13. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.*

## Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Hospice & Home Health MACs, and Durable Medical Equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

## Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

## Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly 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.

## Key Points of CR8865

***Splints, Casts, and Certain Intraocular Lenses (IOLs)***

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The 'IL" payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.

You may want to review MLN Matters® Article MM8645, "*April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf**, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

***Off-the-Shelf (OTS) Orthotics***

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

1. K0901 - Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and
2. K0902 - Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "*Medicare Claims Processing Manual*," Chapter 23, Section 60.3.1. at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf** on the CMS website.

Further information on the development of new OTS orthotic codes can be found at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html** on the CMS website.

***Specific Coding and Pricing Issues***

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of Change Request 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

## Additional Information

The official instruction, CR8865 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3123CP.pdf** on the CMS website.

You may review Attachment B (page 19) of CR6270 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1630CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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## Calendar Year (CY) 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM8999) (GEN)

**MLN Matters® Number: MM8999**
**Related CR Release Date: November 21, 2014**
**Related CR Transmittal #: R3129CP**

**Related Change Request (CR) #: CR 8999**
**Effective Date: January 1, 2015**
**Implementation Date: January 5, 2015**

### Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8999 to advise providers of the CY 2015 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 fee schedule. Make sure your staffs are aware of these updates.

### Background

CMS updates the DMEPOS fee schedules 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 Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

### Key Points

***Fee Schedule Files***

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

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

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

| Factor | |
|---|---|
| 0.459 | Oxygen |
| 0.462 | Capped Rental |
| 0.464 | Prosthetics and Orthotics |
| 0.588 | Surgical Dressings |
| 0.640 | Parenteral and Enteral Nutrition |
| 0.963 | Intraocular Lenses |
| 0.980 | Splints and Casts |

***Specific Coding and Pricing Issues***

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order 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 2015, 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 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

***Diabetic Testing Supplies (DTS)***

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the *American Taxpayer Relief Act of 2012*, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR8204, dated February 22, 2013. The MLN Matters® article related to CR8204 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf** on the CMS website.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.5% for CY 2015. The single payment amount public use file for the national mail order competitive bidding program is available at **http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts** on the Internet.

***2015 Fee Schedule Update Factor of 1.5 Percent***

For CY 2015, the update factor of 1.5 percent is applied to the applicable CY 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, 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 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

***2015 Update to the Labor Payment Rates***

The table below contains the CY 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for CY 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

| STATE | K0739 | L4205 | L7520 |
|---|---|---|---|
| AK | $27.98 | $31.88 | $37.50 |
| AL | $14.86 | $22.14 | $30.05 |
| AR | $14.86 | $22.14 | $30.05 |
| AZ | $18.37 | $22.11 | $36.97 |
| CA | $22.79 | $36.34 | $42.35 |
| CO | $14.86 | $22.14 | $30.05 |
| CT | $24.81 | $22.63 | $30.05 |
| DC | $14.86 | $22.11 | $30.05 |
| DE | $27.35 | $22.11 | $30.05 |
| FL | $14.86 | $22.14 | $30.05 |
| GA | $14.86 | $22.14 | $30.05 |
| HI | $18.37 | $31.88 | $37.50 |
| IA | $14.86 | $22.11 | $35.97 |
| ID | $14.86 | $22.11 | $30.05 |
| IL | $14.86 | $22.11 | $30.05 |
| IN | $14.86 | $22.11 | $30.05 |
| KS | $14.86 | $22.11 | $37.50 |
| KY | $14.86 | $28.34 | $38.43 |
| LA | $14.86 | $22.14 | $30.05 |
| MA | $24.81 | $22.11 | $30.05 |
| MD | $14.86 | $22.11 | $30.05 |
| ME | $24.81 | $22.11 | $30.05 |
| MI | $14.86 | $22.11 | $30.05 |
| MN | $14.86 | $22.11 | $30.05 |
| MO | $14.86 | $22.11 | $30.05 |
| MS | $14.86 | $22.14 | $30.05 |
| MT | $14.86 | $22.11 | $37.50 |

| STATE | K0739 | L4205 | L7520 |
|---|---|---|---|
| NC | $14.86 | $22.14 | $30.05 |
| ND | $18.51 | $31.81 | $37.50 |
| NE | $14.86 | $22.11 | $41.90 |
| NH | $15.95 | $22.11 | $30.05 |
| NJ | $20.04 | $22.11 | $30.05 |
| NM | $14.86 | $22.14 | $30.05 |
| NV | $23.67 | $22.11 | $40.96 |
| NY | $27.35 | $22.14 | $30.05 |
| OH | $14.86 | $22.11 | $30.05 |
| OK | $14.86 | $22.14 | $30.05 |
| OR | $14.86 | $22.11 | $43.21 |
| PA | $15.95 | $22.77 | $30.05 |
| PR | $14.86 | $22.14 | $30.05 |
| RI | $17.70 | $22.79 | $30.05 |
| SC | $14.86 | $22.14 | $30.05 |
| SD | $16.60 | $22.11 | $40.18 |
| TN | $14.86 | $22.14 | $30.05 |
| TX | $14.86 | $22.14 | $30.05 |
| UT | $14.90 | $22.11 | $46.79 |
| VA | $14.86 | $22.11 | $30.05 |
| VI | $14.86 | $22.14 | $30.05 |
| VT | $15.95 | $22.11 | $30.05 |
| WA | $23.67 | $32.44 | $38.53 |
| WI | $14.86 | $22.11 | $30.05 |
| WV | $14.86 | $22.11 | $30.05 |
| WY | $20.71 | $29.50 | $41.90 |
| WY | $20.71 | $29.50 | $41.90 |

***2015 National Monthly Payment Amounts for Stationary Oxygen Equipment***

As part of CR8999, CMS is implementing the 2015 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, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

When updating the stationary oxygen equipment fees, 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.

***2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment***

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR6792, dated February 5, 2010, (see the article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf**) and Transmittal 717, CR6990, dated June 8, 2010, (see the related article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf**).

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 Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

***Update to Change Request (CR) 8566***

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

## Additional Information

The official instruction for CR8999 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3129CP.pdf** on the CMS website. If you have questions please contact your MAC at their toll-free number. The number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

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# January 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8912) (DRU)

**MLN Matters® Number: MM8912**
**Related CR Release Date: September 19, 2014**
**Related CR Transmittal #: R3072CP**

**Related Change Request (CR) #: CR 8912**
**Effective Date: January 1, 2015**
**Implementation Date: January 5, 2015**

## Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

## Provider Action Needed

Change Request (CR) 8912 instructs Medicare Administrative Contractors (MACs) to download and implement the January 2015 and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2014, July 2014, April 2014, and January 2014, average sales price (ASP) drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2015, with dates of service January 1, 2015, through March 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

### Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted that manufacturers submit to CMS. CMS will supply MACs 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 are in Chapter 4, section 50, of the "*Medicare Claims Processing Manual*" 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 Dates of Service |
|---|---|
| January 2015 ASP and ASP NOC | January 1, 2015, through March 31, 2015 |
| October 2014 ASP and ASP NOC | October 1, 2014, through December 31, 2014 |
| July 2014 ASP and ASP NOC | July 1, 2014, through September 30, 2014 |
| April 2014 ASP and ASP NOC | April 1, 2014, through June 30, 2014 |
| January 2014 ASP and ASP NOC | January 1, 2014, through March 31, 2014 |

### Additional Information

The official instruction, CR 8912 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3072CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

## Fee Schedule Updates (GEN)

The 2014 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.aspx**. This quarter the following notices have been posted:

The following Fee Schedules have been added:

- 4th Quarter 2014 Jurisdiction A DME MAC Fee Schedule
- 4th Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2014 Oral Anticancer Drug Fees

The following Fee Schedules have been revised:

- 3rd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File

**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.**

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## Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE (MM8983) (GEN)

**MLN Matters® Number: MM 8983**
**Related CR Release Date: November 26, 2014**
**Related CR Transmittal #: R3135CP**
**Related Change Request (CR) #: CR 8983**
**Effective Date: April 1, 2015**
**Implementation Date: April 6, 2015**

### Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

### Provider Action Needed

Change Request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2015, and CR8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.

Visit **http://www.wpc-edi.com/reference** for CARC and RARC updates and **http://www.caqh.org/CORECodeCombinations.php** for CAQH CORE defined code combination updates.

### Background

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

Through the *Affordable Care Act*, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The *Affordable Care Act* defines operating rules and specifies the role of operating rules in relation to the standards.

**Note:** *Per Affordable Care Act mandate, all health plans, including Medicare, must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of four Business Scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined Business Scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.*

### Additional Information

The official instruction for CR8983 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3135CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

# 2015 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update (MM8943) (GEN)

**MLN Matters® Number: MM8943**
**Related CR Release Date: October 3, 2014**
**Related CR Transmittal #: R3088CP**

**Related Change Request (CR) #: CR 8943**
**Effective Date: January 1, 2015**
**Implementation Date: January 5, 2015**

## Provider Types Affected

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

## Provider Action Needed

***Impact to You***

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 8943 could impact your payments.

***What You Need to Know***

CR 8943 provides the 2015 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems.

By the first week in December 2014, the new code files for B MAC processing, and the new Excel and PDF files for A MAC processing will be available at **http://www.cms.gov/SNFConsolidatedBilling** on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2015.

***What You Need to Do***

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

## Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. These edits allow separate payment for only those services that are excluded from consolidated billing.

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the "*Medicare Claims Processing Manual*," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf** on the CMS website.

## Additional Information

The official instruction, CR 8943, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3088CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

# Update to Medicare Deductible, Coinsurance, and Premium Rates for 2015 (MM8982) (GEN)

**MLN Matters® Number: MM8982**
**Related CR Release Date: November 21, 2014**
**Related CR Transmittal #: R89GI**

**Related Change Request (CR) #: CR 8982**
**Effective Date: January 1, 2015**
**Implementation Date: January 5, 2015**

## Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment MACs, for services to Medicare beneficiaries.

## Provider Action Needed

Change Request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new Calendar Year (CY) 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff are aware of these changes.

## Background

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

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

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

***2015 PART A - HOSPITAL INSURANCE (HI)***

- Deductible: $1,260.00
- Coinsurance:
  - $315.00 a day for 61st-90th day
  - $630.00 a day for 91st-150th day (lifetime reserve days)
  - $157.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- Base Premium (BP): $407.00 a month
- BP with 10% surcharge: $447.70 a month
- BP with 45% reduction: $224.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45% reduction and 10% surcharge: $246.40 a month

***2015 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)***

- Standard Premium: $104.90 a month
- Deductible: $147.00 a year
- Pro Rata Data Amount:
  - $114.99 1st month
  - $32.01 2nd month

- Coinsurance: 20 percent

## Additional Information

The official instruction, CR 8982, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R89GI.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

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# 2014-2015 Influenza (Flu) Resources for Health Care Professionals (SE1431) (GEN)

**MLN Matters® Number: SE1431**
**Related CR Release Date: NA**
**Related CR Transmittal #: NA**
**Related Change Request (CR) #: NA**
**Effective Date: NA**
**Implementation Date: NA**

## Provider Types Affected

All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

## What You Need to Know

- Keep this Special Edition MLN Matters article and refer to it throughout the 2014 - 2015 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

## Introduction

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

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

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

**Know What to Do About the Flu!**

## Educational Products for Health Care Professionals

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

**1. MLN Influenza Related Products for Health Care Professionals**

- **MLN Matters Article MM8890: Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season**
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8890.pdf**

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

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

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

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

**2. Other CMS Resources**

- **Seasonal Influenza Vaccines 2014 Pricing**
  **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2014ASPFiles.html**

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

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

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

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

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

**3. Other Resources**

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2014 - 2015 flu season:

- **Advisory Committee on Immunization Practices - http://www.cdc.gov/vaccines/acip/index.html**

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

## Beneficiary Information

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

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

Remember to immunize yourself and your staff. *Protect yourself from the flu.*

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

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

## CMS 1500 Claim Form Instructions: Revised for Form Version 02/12 (MM8509) (GEN)

**MLN Matters® Number: MM8509 Revised**
**Related CR Release Date: October 2, 2014**

**Related CR Transmittal #: R3083CP**

**Related Change Request (CR) #: CR 8509**
**Effective Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10**
**Implementation Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10**

**Note:** *This article was revised on October 6, 2014, to reflect the revised CR8509 issued on October 2. In the article, the effective and implementation dates have changed and the CR release date, transmittal number and the Web address for accessing the CR are changed. All other information is the same.*

### Provider Types Affected

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

### Provider Action Needed

***Impact to You***

This change request (CR) 8509 revises the current CMS 1500 claim form instructions to reflect the revised CMS 1500 claim form, version 02/12.

***What You Need to Know***

Form Version 02/12 will replace the current CMS 1500 claim form, 08/05, effective with claims received on and after April 1, 2014:

- Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014;
- Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014;
- On April 1, 2014, Medicare will accept paper claims on only the revised CMS 1500 claim form, 02/12; and
- On and after April 1, 2014, Medicare will no longer accept claims on the old CMS 1500 claim form, 08/05.

***What You Need to Do***

Make sure that your billing staff are aware of these instructions for the revised form version 02/12.

## Background

The National Uniform Claim Committee (NUCC) recently revised the CMS 1500 claim form. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

- DN - Referring Provider
- DK - Ordering Provider
- DQ - Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

The *Administrative Simplification Compliance Act* (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the CMS 1500 claim form. Medicare therefore supports the implementation of the CMS 1500 claim form and its revisions for use by its professional providers and suppliers meeting an ASCA exception. More information about ASCA exceptions can be found in Chapter 24 of the "*Medicare Claims Processing Manual*" which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

## Additional Information

The official instruction, CR 8509 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3083CP.pdf** on the CMS website. CR 8509 contains the instructions for completing the revised CMS 1500 claim form (02/12), which will become part of Chapter 26 in the "*Medicare Claims Processing Manual*" (Pub. 100-04).

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

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# Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN) (SE1216) (GEN)

**MLN Matters® Number: SE1216 Revised**
**Related CR Release Date: N/A**
**Related CR Transmittal #: N/A**
**Related Change Request (CR) #: N/A**
**Effective Date: N/A**
**Implementation Date: N/A**

**Note:** *This article was revised on September 5, 2014, to add the "Where Can I Find My PTAN?" section on page 3. All other information is the same.*

## Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

## What You Need to Know

This article explains the difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). There are no policy changes in this article.

## Background

***New Enrollees***

**All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare Administrative Contractor (MAC), the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.**

***Revalidation***

Section 6401(a) of the *Affordable Care Act* established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

***National Provider Identifier (NPI)***

The NPI is a **national** standard under the *Health Insurance Portability and Accountability Act* (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render health care or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at **https://nppes.cms.hhs.gov/NPPES/Welcome.do** on the CMS website.

***Provider Transaction Access Number (PTAN)***

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc.
- The PTAN's use should generally be limited to the provider's contacts with their MAC.

***Where can I find my PTAN?***

You can find your PTAN by doing any one of the following:

1. View the letter sent by your MAC when your enrollment in Medicare was approved.
2. Log into Internet-based PECOS (**https://pecos.cms.hhs.gov/pecos/login.do**). Click on the "My Enrollments" button and then "View Enrollments". Locate the applicable enrollment and click on the "View Medicare ID Report" link which will list all of the provider or supplier's active PTANs in one report.
3. The provider (or, in the case of an organizational provider, an authorized or delegated official) shall send a signed written request on company letterhead to your MAC (**http://www.cms.gov/Medicare/Provider-Enrollment-and-**

Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf); include your legal name/legal business name, national provider identifier (NPI), telephone and fax numbers.

***Relationship of the NPI to the PTAN***

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

***Protect Your Information in PECOS***

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use internet-based PECOS: Log on to internet-based PECOS at **https://pecos.cms.hhs.gov/pecos/login.do** on the CMS website.
- Use the Paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- **Note:** The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled "*How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS),*" provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf** on the CMS website.

## Additional Information

MLN Matters® Special Edition Article SE1126 titled "*Further Details on the Revalidation of Provider Enrollment Information,*" is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf** on the CMS website.

"*Medicare Provider-Supplier Enrollment National Educational Products*," contains a list of products designed to educate Medicare Fee-For-Service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare Program and maintain their enrollment information. This resource is available at **http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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

## Manual Update to Clarify Claims Processing for Laboratory Services (MM8883) (SPE)

**MLN Matters® Number: MM8883**
**Related CR Release Date: September 19, 2014**
**Related CR Transmittal #: R3071CP**
**Related Change Request (CR) #: CR 8883**
**Effective Date: December 22, 2014**
**Implementation Date: December 22, 2014**

### Provider Types Affected

This MLN Matters® Article is intended for Medicare practitioners providing laboratory services to Medicare beneficiaries and billing Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare (DME) MACs for those services.

### Provider Action Needed

Change Request (CR) 8883 updates the "*Medicare Claims Processing Manual*" to clarify that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance. The changes are intended to clarify the existing policies and no system or processing changes are anticipated. Make sure your billing staffs are aware of these policies.

### Key Points

The manual updates, which are attached to CR8883, are as follows:

- The location where the independent laboratory performed the test determines the appropriate billing jurisdiction. If the sample originates in a different jurisdiction from where the sample is being tested, the claim must be filed in the jurisdiction where the test was performed.
- Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent laboratory, the specimen collection fee and travel allowance must be billed in conjunction with a covered laboratory test.
- The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

### Additional Information

The official instruction, CR8883 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3071CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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## Medicare Secondary Payer (MSP) Group Health Plan (GHP) Working Aged Policy - Definition of "Spouse;" Same-Sex Marriages (MM8875) (GEN)

**MLN Matters® Number: MM8875**
**Related CR Release Date: October 10, 2014**
**Related CR Transmittal #: R106MSP**
**Related Change Request (CR) #: CR 8875**
**Effective Date: January 1, 2015**
**Implementation Date: January 1, 2015**

### Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### Provider Action Needed

***Impact to You***

Section 3 of the *Defense of Marriage Act* (DOMA) provided for purposes of federal law, the term "spouse" could not include individuals in a same-sex marriage. Because the MSP Working Aged provisions only apply to subscribers and their spouses, the Working Aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage. The United States

Supreme Court has invalidated this DOMA provision. Thus, the Centers for Medicare & Medicaid Services (CMS) is no longer prohibited from applying the MSP Working Aged provision to individuals in a same-sex marriage.

***What You Need to Know***

Effective January 1, 2015, the rules below apply with respect to the term "spouse" under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages.

- If an individual is entitled to Medicare as a spouse based upon the Social Security Administration's rules, that individual is a "spouse" for purposes of the MSP Working Aged provisions.
- If a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory, or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are "spouses" for purposes of the MSP Working Aged provisions.
- Where an employer, insurer, third party administrator, Group Health Plan (GHP), or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in question. If such an individual is reported as a "spouse" through the *Medicare, Medicaid, and SCHIP Extension Act of 2007* (MMSEA) Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

***What You Need to Do***

Make sure your billing staffs are aware of these changes.

## Background

Based on Change Request (CR) 8875, effective January 1, 2015, the definition of a spouse for purposes of the working aged provisions means "a person who is entitled to Medicare as a spouse based upon the Social Security Administration's rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction."

The expanded rules for the definition of "spouse," including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

To the extent an employer, insurer, third party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader definition of "spouse" for MSP purposes prior to January 1, 2015, it may do so. However, MACs may not apply the revised definition for Medicare purposes for coverage dates prior to January 1, 2015. Nor may MACs accept a definition of spouse broader than that quoted above. In the event, Medicare does pay for coverage prior to January 1, 2015, it will pursue recovery, as applicable.

## Additional Information

The official instruction, CR8875, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106MSP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.



The Provider Services Portal (PSP) is an internet portal available to DME MAC A providers. PSP users can easily access beneficiary eligibility, claims information, DME same/similar and specific A, L & V HCPCS Look-up, reopening, redetermination & overpayment refund form submission and status, as well as print Remittances over the internet.

**The PSP is currently available for open enrollment. There is no charge to participate!**
For more information visit the DME MAC A PSP Home page at:
**http://www.medicarenhic.com/dme/psphome.aspx**

# New Informational Unsolicited Response (IUR) Process for Durable Medical Equipment (DME) Items Furnished during a Part A Inpatient Stay (MM8844) (GEN)

**MLN Matters® Number: MM8844**
**Related CR Release Date: November 6, 2014**
**Related CR Transmittal #: R1435OTN**
**Related Change Request (CR) #: CR 8844**
**Effective Date: April 1, 2015**
**Implementation Date: April 6, 2015**

## 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 an inpatient facility, or other facility.

## Provider Action Needed

Change Request (CR) 8844 is a modification of CR8172 that gave providers guidance regarding the Centers for Medicare & Medicaid Services (CMS) longstanding edits in place to deny claims for DME items furnished during an inpatient stay. CR8172 only addressed Prosthetics and Orthotics and did not include DME. In addition, CR8172 provided instructions for the date of service through discharge date, but did not include day of discharge.

CR8844 provides a modification to include DME and discharge date to the Informational Unsolicited Response (IUR) edit process for DME during a Part A Inpatient Stay. Effective April 1, 2015, Medicare's Common Working File (CWF) will update the existing 7201 IUR edit to trigger recoupment for DME items furnished while the beneficiary was in a hospital inpatient stay. Make sure your billing staffs are aware of these changes.

## Background

Section 1861(n) of the *Social Security Act* limits Part B coverage under the DME benefit to those items that are furnished for use in a patient's home. Inpatient facilities, and other facilities, may not be considered the patient's home. Therefore, payment for DME items may not be made while the beneficiary is in an inpatient facility, or other facility. This applies to the following Healthcare Common Procedure Coding System (HCPCS) categories:

- 01 - Capped Rental DME;
- 02 - Frequently maintained DME;
- 04 - Inexpensive and routinely purchased DME;
- 05 - Electric Wheelchairs;
- 06 - Oxygen equipment; and
- 07 - Oxygen Supplies.

**Note:** *This does not apply when the DME claim has a patient status code of 03 or 83 AND the Skilled Nursing Facility (SNF) claim is not on file. Also, the edit will not apply if the "From" date of the DME claim is the same as an inpatient discharge date and the patient status code on the inpatient claim is 01 (Discharged to home or self-care), 06 (Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care), 50 (Discharged/transferred to Hospice - home), 81 (Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission), or 86 (Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission).*

CMS has edits in place to deny claims for DME items furnished during an inpatient stay. Currently, however, no process is in place to recoup funds for DME items when the bill for the inpatient stay is received after the DME claim.

Effective April 1, 2015, CMS is creating a new IUR process within the CWF to identify DME claims that overlapped a Part A inpatient stay. An IUR identifies a claim that needs to be adjusted by the Medicare Administrative Contractor (MAC). The MAC will receive information from CWF as a result of the IUR, and initiate, when appropriate, the recoupment process for DME items furnished during an inpatient stay.

When your MAC denies a claim for DME when the beneficiary is in an inpatient stay, the denial will include the following remittance codes:

- Reason Code 96 - Non covered charge(s)
- Remark Code M18 - Certain Services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home
- Group Code PR - Patient Responsibility

### Additional Information

The official instruction, CR8844 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1435OTN.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

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## New Physician Specialty Code for Interventional Cardiology (MM8812) (SPE)

**MLN Matters® Number: MM8812 Revised**
**Related CR Release Date: September 23, 2014**
**Related CR Transmittal #: R3073CP, R238FM**

**Related Change Request (CR) #: CR 8812**
**Effective Date: January 1, 2015**
**Implementation Date: January 5, 2015**

**Note:** *This article was revised on September 26, 2014, to reflect the revised CR8812 that was issued on September 23. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.*

### Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

### What You Need to Know

CR 8812, from which this article is taken, provides notice that the Centers for Medicare & Medicaid Services (CMS) is establishing a new physician specialty code for Interventional Cardiology. The CR is also changing the description of specialty code 62, and updating the names associated to specialty codes 88 and 95. Make sure your billing staffs are aware of these changes.

### Background

Physicians who enroll in the Medicare program self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or via the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Non-physician practitioners who enroll with Medicare are assigned a Medicare specialty code. These Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. They become associated with the claims that physician or non-physician practitioners submit; and are used by CMS for programmatic and claims processing purposes.

CR 8812 establishes a new physician specialty code for Interventional Cardiology (C3). CR8812 is also removing the word "Clinical" from the description of specialty code 62 (Psychologist (Billing Independently)), and is changing the description of specialty code 88 to "Unknown Provider," and of specialty code 95 to "Unknown Supplier". The changes to the descriptions for codes 88 and 95 align their names with their intended usages.

### Additional Information

The official instruction, CR 8812 issued to your MAC regarding this change is available in 2 transmittals at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3073CP.pdf** and **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R238FM.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

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## New Timeframe for Response to Additional Documentation Requests (MM8583) (GEN)

**MLN Matters® Number: MM8583 Revised**
**Related CR Release Date: November 14, 2014**
**Related CR Transmittal #: R554PI**

**Related Change Request (CR) #: CR 8583**
**Effective Date: April 1, 2015**
**Implementation Date: April 6, 2015**

**Note:** *This article was revised on November 18, 2014, to make corrections in the article, especially to clarify ADR requirements related to pre-payment review.*

### Provider Types Affected

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

### What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

### Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The *Social Security Act*, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the "*Medicare Program Integrity Manual*," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions),when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

### Additional Information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R554PI.pdf on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

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## Pub 100-03, Chapter 1, Language-only Update (MM8506) (GEN)

**MLN Matters® Number: MM8506 Revised**
**Related CR Release Date: September 4, 2014**
**Related CR Transmittal #: R173NCD**
**Related Change Request (CR) #: CR 8506**
**Effective Date: Upon ICD-10 Implementation**
**Implementation: Upon ICD-10 Implementation**

**Note:** *This article was revised on September 8, 2014, to reflect the revised CR8506 issued on September 4. The CR release date, effective and implementation dates, transmittal number, and the Web address for accessing the CR are revised. All other information is unchanged.*

### Provider Types Affected

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

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8506 as an informational alert to providers that language-only changes - updates to the "*Medicare National Coverage Determinations (NCD) Manual*", Pub 100-03 - were made. The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

**Note:** *The edits made to the NCD Manual are technical/editorial only and in no way alter existing NCD policies.*

### Background

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

### Additional Information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R173NCD.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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## Revised Centers for Medicare & Medicaid Services (CMS) 855R Application - Reassignment of Medicare Benefits (SE1432) (GEN)

**MLN Matters® Number: SE1432**
**Related CR Release Date: N/A**
**Related CR Transmittal #: N/A**
**Related Change Request (CR) #: NA**
**Effective Date: June 1, 2015**
**Implementation Date: May 31, 2015**

### Provider Types Affected

This MLN Matters® Special Edition (SE) is intended for physicians, non-physician practitioners, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) and who choose to reassign their benefits or accept reassigned benefits of those claims.

## Provider Action Needed

***Impact to You***

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R (Reassignment of Benefits) application beginning June 1, 2015.

***What You Need to Know***

The revised CMS 855R application will be available for use on the CMS.gov website as of December 29, 2014. MACs may accept both the current and revised versions of the CMS 855R through May 31, 2015, after which the revised CMS 855R application will be required to be submitted.

After May 31, 2015, MACs will return any newly submitted CMS 855R applications on the previous version (07/11) to the provider/supplier with a letter explaining that the CMS 855R has been updated and the current version of the CMS 855R (11/12) must be submitted.

***What You Need to Do***

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

## Background

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R application starting June 1, 2015. The revised CMS 855R has been streamlined and some sections have been re-ordered for clarity. The revised form includes an optional section for primary practice location address. This information is shared with other programs such as Physician Compare to help beneficiaries identify where their physicians are primarily practicing. This address must be one that is affiliated with the individual/organization where the benefits are being reassigned.

## Additional Information

Visit the Medicare Provider Supplier Enrollment webpage for more information about Medicare enrollment, available at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html** on the CMS website.

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# Transitioning Medicare Administrative Contractor (MAC) Workloads to the New Banking Contractor(s) (MM8847) (GEN)

**MLN Matters® Number: MM8847**
**Related CR Release Date: September 19, 2014**
**Related CR Transmittal #: R240FM**

**Related Change Request (CR) #: CR 8847**
**Effective Date: September 19, 2014**
**Implementation Date: September 30, 2014**

## Provider Types Affected

This MLN Matters® Article is intended to alert all providers that your Medicare Administrative Contractor (MAC) may be transitioning their banking to another bank.

## What You Need to Know

This article is informational in nature and is intended to inform you that Medicare has re-competed its banking contracts and has awarded two new five year contracts to US Bank (an incumbent bank) and to Citibank (which replaces the prior contract with JP Morgan Chase). The Centers for Medicare & Medicaid Services (CMS) awarded these new contracts on July 10, 2014. Change Request (CR) 8847 was issued to manage the transition of the MAC workloads from JP Morgan Chase to Citibank.

## Background

In 2010, CMS changed its Medicare banking policies by discontinuing the use of time accounts to pay for banking service charges and awarded five year commercial services contracts through full and open competition to two banks (US Bank and JP Morgan Chase); these two banks disburse MAC authorized payments and Demonstration project payments for CMS. The two current commercial banking contracts are terminating in Fiscal Year 2015. CMS has awarded new five year contracts through full and open competition to

US Bank (incumbent bank) and Citibank (new bank). Each selected bank shall provide both MAC payment services and Demonstration payment services and shall be designated Financial Agents of the U.S. Treasury.

CMS is transitioning MAC workloads from JP Morgan Chase to Citibank. The MAC workloads with US Bank will remain with US Bank. The transition began in August 2014 and will end in January 2015.

### Additional Information

The official instruction for CR8847 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R240FM.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

## CMS News Flash (GEN)

### NEW product from the Medicare Learning Network® (MLN)

- "*Medicaid Compliance and Your Dental Practice*"
  Fact Sheet, ICN 908668, downloadable
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicaid_Compliance_ICN908668.pdf**

- "*Vaccine Payments Under Medicare Part D*"
  Fact Sheet, ICN 908764, downloadable and hard copy
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764.pdf**

- "*The CMS Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014*"
  Web-Based Training (WBT)
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html**

- "*Medicaid Compliance and Your Dental Practice*"
  Fact Sheet, ICN 908668, Downloadable only
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicaid_Compliance_ICN908668.pdf**

### REVISED product from the Medicare Learning Network® (MLN)

- "*Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities*"
  Educational Tool, ICN 906983, downloadable
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ContractorEntityGuide_ICN906983.pdf**

- "*Medicare Shared Savings Program and Rural Providers*"
  Fact Sheet, ICN 907408, downloadable
  **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Rural_Factsheet_ICN907408.pdf**

- "*Medicare Learning Network® (MLN) Suite of Products & Resources for Educators and Students*"
  Educational Tool, ICN 903763, Downloadable only
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLN_Suite_of_Products_and_Resources_for_Instructors.pdf**

- "*Medicare Learning Network® (MLN) Suite of Products & Resources for Compliance Officers*"
  Educational Tool, ICN 908525, Downloadable only
  **http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/ComplianceOfficers.pdf**

- "*Medicare Appeals Process*"
  Fact Sheet, ICN 006562, Downloadable
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareAppealsProcess.pdf**

- "*The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation*"
  Fact Sheet, ICN 905710, Downloadable only
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DMEPOS_Basics_FactSheet_ICN905710.pdf**

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

- "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies*"
  Fact Sheet, ICN 905711, Downloadable only
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DMEPOS_Pharm_Factsheet_ICN905711.pdf**

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

- "*ICD-10-CM/PCS Billing and Payment Frequently Asked Questions*"
  Fact Sheet (ICN 908974), Hard Copy
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/September-2013-ICD-10-CM-PCS-Billing-Payment-FAQs-Fact-Sheet-ICN908974.pdf**

- "*Evaluation and Management Services*"
  Guide (ICN 006764), downloadable
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf**

## Recognizing Lung Cancer Awareness Month and the Great American Smokeout

November is Lung Cancer Awareness Month and November 20 is the Great American Smokeout. Lung cancer is the leading cause of cancer death in the United States for both men and women. Cigarette smoking is the number one cause of lung cancer. Almost 1 in 5 Americans smokes cigarettes, and tens of thousands more smoke pipes or cigars, which also cause lung cancer. Many smokers who want to quit have great difficulty succeeding. As a provider of health care services to people with Medicare, you can provide support to seniors who want to quit tobacco use, and Medicare can help. Read more at:
**http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Mesages-New-Items/2014-11-07-Lung-Cancer-Awareness.html**

## MLN Matters® Articles Index

Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/** on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every

month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

## Raising Awareness of Diabetes in November

During the month of November, the United States draws attention to diabetes and its impact on public health through several national health observances, including National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day. Millions of Americans have diabetes and don't know it. Left undiagnosed or untreated, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney disease, amputation, and even premature death. Read more at: **http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Mesages-New-Items/2014-11-02-World-Diabetes-Day.html** to learn about the preventive services covered by Medicare that focus on early disease detection and disease management.

## Electronic Funds Transfer (EFT)

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official. For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article SE1126 (**https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf**), "*Further Details on the Revalidation of Provider Enrollment Information*"

## Flu Vaccination

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

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

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

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

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

# MLN Connects™ Provider eNews (GEN)

## MLN Connects™ Provider eNews for September 11, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-09-11-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-09-11-eNews.pdf

***MLN Connects™ National Provider Calls***

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs - Last Chance to Register

***Announcements***

- Hospitals Appeals Settlement FAQs
- National Cholesterol Education Month - Medicare Preventive Services for Cardiovascular Disease
- New Release of PEPPER for Short-term Acute Care Hospitals
- EHR Incentive Programs: Learn More about Patient Electronic Access Requirements
- EHR Incentive Programs: Exclusions and Hardship Exceptions for Broadband Access

***Claims, Pricers, and Codes***

- Incarcerated Beneficiary Update
- Updated Information on Preventive Services Paid Based on the RHC or FQHC All-Inclusive Rate
- October 2014 Average Sales Price Files Now Available

***MLN Educational Products***

- "HIPAA Privacy and Security Basics for Providers" Fact Sheet - Released
- "The CMS Physician Quality Reporting System (PQRS) Program: What Medicare Eligible Professionals Need to Know in 2014" Web-Based Training Course - Released
- "The CMS Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014" Web-Based Training Course - Released
- "The Medicare and Medicaid EHR Incentive Programs: What Medicare and Medicaid Providers Need to Know in 2014" Web-Based Training Course - Released
- "Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" MLN Matters® Article - Revised
- "Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes - Companion Information to MM8581: Automation of the Request for Reopening Claims Process" MLN Matters® Article - Revised
- New MLN Topic of the Month

## MLN Connects™ Provider eNews for September 18, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-09-18-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-09-18-eNews-file.pdf

**Be sure to check out the upcoming calls and event on ICD-10 and the Hospital Appeals Settlement in this week's edition!**

***MLN Connects™ National Provider Calls***

- Hospital Appeals Settlement Update - Registration Opening Soon
- Transitioning to ICD-10 - Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

***CMS Events***

- ICD-10 Coordination and Maintenance Committee Meeting

***Announcements***

- New *Affordable Care Act* Tools and Payment Models Deliver $372 Million in Savings, Improve Care
- HHS Provides Additional Flexibility for Certification of Electronic Health Record Technology
- Medicare EHR Incentive Program: October 3 Last Day for 1st-year EPs to Begin 2014 Reporting Period

***Claims, Pricers, and Codes***

- Mass Adjustments to IPF Claims with Teaching Adjustment Amounts Being Duplicated

***MLN Educational Products***

- "2014-2015 Influenza (Flu) Resources for Health Care Professionals" MLN Matters® Article - Released
- "Internet-based PECOS FAQs" Fact Sheet - Released
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet - Released
- "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet - Revised
- "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" Fact Sheet - Revised
- MLN Products Available In Electronic Publication Format

## MLN Connects™ Provider eNews for September 25, 2014

**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-09-25-eNews.html**

View this edition as a PDF
**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-09-25-eNews.pdf**

**Don't miss important information on PQRS, eRx & the Hospital Appeals Settlement in this week's edition!**

***MLN Connects™ National Provider Calls***

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings - Registration Opening Soon
- Hospital Appeals Settlement Update - Registration Now Open
- Transitioning to ICD-10 - Register Now
- New MLN Connects™ National Provider Call Video Slideshow

***Announcements***

- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- National Partnership to Improve Dementia Care Exceeds Goal to Reduce Use of Antipsychotic Medications in Nursing Homes: CMS Announces New Goal
- Hospital Appeals Settlement: New FAQs Posted
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- 2014 PQRS 2nd Quarter Interim Feedback Dashboard Reports Available
- 2013 PQRS and eRx Incentive Program Incentive Payments Available
- 2013 PQRS and eRx Incentive Program Feedback Reports Available
- 2012 eRx Incentive Program and 2012 PQRS Supplemental Incentive Payments Available
- Completion and Submission Timeframes for Hospice Item Set Records
- Important Skill Sets for Doctors and Nurses: CME Articles Available on Medscape
- New Resources and Webinars from National Health IT Week
- PQRS: New Quality Reporting Training Modules to Help Ensure Satisfactory 2014 Reporting
- 2014 CAHPS for PQRS Survey
- New PQRS FAQs Available
- New and Updated FAQs for the EHR Incentive Programs

***Claims, Pricers, and Codes***

- FDG PET for Solid Tumor Claims

***Medicare Learning Network® Educational Products***

- "Medicare Billing Information for Rural Providers and Suppliers" Booklet - Revised
- "Rural Health Clinic" Fact Sheet - Revised
- "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Fact Sheet - Revised
- "Critical Access Hospital" Fact Sheet - Revised
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

## MLN Connects™ Provider eNews for October 02, 2014

**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-10-02-eNews.html**

View this edition as a PDF
**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-10-02-enews.pdf**

***MLN Connects™ National Provider Calls***

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings - Last Chance to Register
- Hospital Appeals Settlement Update - Last Chance to Register
- Overview of the 2013 Quality and Resource Use Reports - Registration Opening Soon
- Transitioning to ICD-10 - Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript

***CMS Events***

- Special Open Door Forum: Star Ratings on Dialysis Facility Compare

***Announcements***

- National Breast Cancer Awareness Month
- CMS Makes First Wave of Drug and Device Company Payments to Teaching Hospitals and Physicians Public
- Get Ready for DMEPOS Competitive Bidding - Common Ownership and Common Control
- PQRS GPRO Registration Extended Until October 3
- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- Comply with MAC Request for Fingerprints within 30 Days
- CMS Announces Availability of 2013 Quality and Resource Use Reports
- EHR Incentive Program: CMS Attestation System Open
- ICD-10 Compliance Date Is October 1, 2015

***Claims, Pricers, and Codes***

- ICD-10-CM Official Guidelines for Coding and Reporting Available

***Medicare Learning Network® Educational Products***

- "Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision" Fact Sheet - Revised
- "Medicare Appeals Process" Fact Sheet - Revised
- Medicare Learning Network® Products Available In Electronic Publication Format
- New Medicare Learning Network® Provider Compliance Fast Fact

## MLN Connects™ Provider eNews for October 09, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-10-09-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-10-09-eNews-file.pdf

***MLN Connects™ National Provider Calls***

- Overview of the 2013 Quality and Resource Use Reports - Registration Now Open
- CMS 2014 Certified EHR Technology Flexibility Rule - Registration Now Open
- Transitioning to ICD-10 - Register Now

***MLN Connects™ Videos***

- Monthly Spotlight: Physician Quality Reporting System

***Announcements***

- CMS Announces Two Medicare Quality Improvement Initiatives
- New Outreach & Education Page at CMS.gov
- Work with Older Adult Patients? New Medscape Video for CME Credit
- Electronic Funds Transfer Upgrades to the Internet-based PECOS System
- Open Payments: Know the Numbers and Decode the Data
- CMS is Accepting Suggestions for Potential PQRS Measures
- PQRS: Physician Compare 2013 Group Practice Quality Measure Preview Period through November 7
- New FAQs for PQRS
- EHR Incentive Programs: Hardship Exception Applications to Avoid 2015 Payment Adjustment due November 30
- EHR Incentive Programs: Eligible Hospitals and Requirements for CEHRT to Participate in 2015
- EHR Incentive Programs: Learn How to Report 2014 eCQMs through the QualityNet Portal

***Medicare Learning Network® Educational Products***

- "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet - Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

## MLN Connects™ Provider eNews for October 16, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-10-16-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-10-16-eNews.pdf

***MLN Connects™ National Provider Calls***

- Hospital Appeals Settlement Update 2 - Registration Opening Soon
- Overview of the 2013 Quality and Resource Use Reports - Last Chance to Register
- CMS 2014 Certified EHR Technology Flexibility Rule - Register Now
- Transitioning to ICD-10 - Register Now

***MLN Connects™ Videos***

- New Videos on ICD-10: Medicare Testing Plans and Home Health Conversion
- Did You Miss the Hospital Appeals Settlement Video?

***Announcements***

- Proposed Rule on Conditions of Participation for HHAs - Comments due December 8
- Get Ready for DMEPOS Competitive Bidding
- Cutting-edge Colorectal Cancer Screening Now Covered

***Claims, Pricers, and Codes***

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hold on FQHC Medicare Advantage PPS Claims

***Medicare Learning Network® Educational Products***

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports" Educational Tool - Released
- "Reading a Professional Remittance Advice (RA)" Booklet - Released
- "Reading the Institutional Remittance Advice (RA)" Booklet - Released
- "Medicare Disproportionate Share Hospital" Fact Sheet - Revised
- "Medicare Secondary Payer Provisions" Web-Based Training Course - Revised
- "CMS Website Wheel" Educational Tool - Reminder
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet - Reminder
- Medicare Learning Network® Product Available in Electronic Publication Format

## MLN Connects™ Provider eNews for October 23, 2014

**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-10-23-eNews.html**

View this edition as a PDF
**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-10-23-eNews-file.pdf**

***MLN Connects™ National Provider Calls***

- CMS 2014 Certified EHR Technology Flexibility Rule - Last Chance to Register
- Transitioning to ICD-10 - Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

***CMS Events***

- Webinar for Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds

***Announcements***

- Protect Your Patients Against Influenza and Pneumonia
- Updated CDC Resource Available on Ebola
- New *Affordable Care Act* Initiative to Support Care Coordination Nationwide
- Extension of Shared Savings Program Fraud and Abuse Waivers Interim Final Rule
- IRF Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- LTCH Quality Reporting Program: NHSN Quality Data Submission Deadline Extended to November 15
- Open Payments Search Tool Now Available
- Open Payments: Start Preparing for the 2014 Reporting Year
- Comparative Billing Report on Podiatry: Debridement of Ulcers and Wounds
- EHR Incentive Programs: Protect Electronic Health Information Core Objective

***Claims, Pricers, and Codes***

- FQHC PPS Issue with Claims Containing Both Preventive and Non-Preventive Services
- Hold on FQHC Medicare Advantage PPS Claims - Update
- Use of HCPCS X Modifiers for Distinct Procedural Services
- Mass Adjustment of Selected SNF Inpatient Claims
- October 2014 Outpatient Prospective Payment System Pricer File Update

***Medicare Learning Network® Educational Products***

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 1]" Educational Tool - Released
- Medicare Learning Network® Web-Based Training Programs
- Updated MLN Matters® Search Indices

## MLN Connects™ Provider eNews for October 30, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-10-30-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-10-30-eNews.pdf

### *MLN Connects™ National Provider Calls*

- Transitioning to ICD-10 - Last Chance to Register

### *Announcements*

- HHS Secretary Announces $840 Million Initiative to Improve Patient Care and Lower Costs
- Hospital Appeals Settlement: Act by October 31
- Get Ready for DMEPOS Competitive Bidding
- SNF PPS Payment Reform Research Project
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Third Quarter Hospice Item Set Question and Answer Document Available
- EHR Incentive Program: Hardship Exception Applications Due November 30
- PQRS: Submission Engine Validation Tool is Now Available for Testing

### *Claims, Pricers, and Codes*

- Physicians, Providers, and Suppliers Must Use Revised CMS 855R Starting May 31
- Demand Letters for Polysomnography Claims

### *Medicare Learning Network® Educational Products*

- "ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" - Revised
- "ICD-10-CM/PCS The Next Generation of Coding" - Revised
- "ICD-10-CM/PCS Myths and Facts" - Revised
- "ICD-10-CM Classification Enhancements" - Revised
- "General Equivalence Mappings Frequently Asked Questions" - Revised
- Medicare Learning Network® Web-Based Training Course with Continuing Education Credits
- Medicare Learning Network® Products Available in Electronic Publication Format

## MLN Connects™ Provider eNews for November 6, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-11-06-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-11-06-eNews.pdf

### *MLN Connects™ National Provider Calls*

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs - Registration Opening Soon
- National Partnership to Improve Dementia Care in Nursing Homes - Registration Now Open
- Certifying Patients for the Medicare Home Health Benefit - Registration Opening Soon
- New MLN Connects™ National Provider Call Audio Recording and Transcript

### *MLN Connects™ Videos*

- Monthly Spotlight: Medicare Preventive Services

***Announcements***

- CY 2015 Policy and Payment Changes to the Medicare Physician Fee Schedule
- CY 2015 Policy and Payment Changes for ESRD Facilities and Implementation of Competitive Bidding-Based Prices for DMEPOS
- CY 2015 Payment and Policy Changes for Hospital Outpatient and Ambulatory Surgical Centers
- CY 2015 Payment Changes for Medicare Home Health Agencies
- Raising Awareness of Diabetes in November
- Final Rule Changes for Open Payments
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the *Affordable Care Act*
- CMS is Accepting Suggestions for Potential PQRS Measures
- Comparative Billing Report on Modifier 25: Family Practice

***Medicare Learning Network® Educational Products***

- "Medicare Appeals Process" Podcast - New
- "Skilled Nursing Facility Prospective Payment System" Fact Sheet - Revised
- "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet - Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

## MLN Connects™ Provider eNews for November 13, 2014

**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-11-13-eNews.html**

View this edition as a PDF
**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-11-13-eNews.pdf**

***MLN Connects™ National Provider Calls***

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs - Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Certifying Patients for the Medicare Home Health Benefit - Registration Now Open
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

***CMS Events***

- Participate in ICD-10 Acknowledgement Testing Week: November 17 through 21, 2014

***Announcements***

- Recognizing Lung Cancer Awareness Month and the Great American Smokeout
- Dialysis Facility Compare Star Ratings and Data Release for January 2015
- Coverage of Speech Generating Devices
- Clinical Laboratory Improvement Amendments Proposed Rule
- PQRS Negative Payment Adjustment
- FY 2016 IRF Quality Reporting Program Submission Deadline: November 15
- FY 2016 LTCH Quality Reporting Program Submission Deadline: November 15
- OASIS Updates for Home Health Agencies
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Program: Deadlines for 2014 Hospital Reporting on November 30
- Changes to Medicare EHR Incentive Program Hardship Exceptions
- ICD-10 Resources for Small Physician Practices on Medscape

***Claims, Pricers, and Codes***

- ICD-10 MS-DRG v32 Definitions Manual and Medicare Code Editor Files Available
- 2015 HCPCS Annual Update
- Acute Inpatient PPS FY 2015.2 Software Release Available
- FDG PET for Solid Tumors: Claims Hold Extension

***Medicare Learning Network® Educational Products***

- "Safeguarding Your Medical Identity" Web-Based Training Course - Revised
- "Medicare Enrollment and Claim Submission Guidelines" Booklet - Revised
- "Medicaid Program Integrity: Understanding and Preventing Provider Medical Identity Theft" Booklet - Revised
- "Medicaid Program Integrity: Preventing Provider Medical Identity Theft" Fact Sheet - Revised
- "Medicaid Program Integrity: Safeguarding Your Medical Identity Using Continuing Medical Education (CME)" Educational Tool - Revised
- Medicare Learning Network® Products Available in Electronic Publication Format

## MLN Connects™ Provider eNews for November 20, 2014

**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-11-20-eNews.html**

View this edition as a PDF
**http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-11-20-eNews.pdf**

***MLN Connects™ National Provider Calls***

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Certifying Patients for the Medicare Home Health Benefit - Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript

***CMS Events***

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar - Registration Open

***Announcements***

- National Home Care and Hospice Month
- Seasonal Influenza and Diabetes Awareness
- *Affordable Care Act* and Health Care Coverage: CME Articles on Medscape
- Prior Authorization Process for Repetitive, Scheduled, Non-Emergent Ambulance Transport
- 2013 QRURs Available
- PEPPER Still Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Distribution of 2012 PQRS Supplemental Incentive Payments
- EHR Incentive Program: How to Report Once in 2014 for Medicare Quality Reporting Programs
- EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2

***Medicare Learning Network® Educational Products***

- The Medicare Learning Network® Autumn 2014 Catalog - Released
- "Revised Centers for Medicare & Medicaid Services (CMS) 855R Application - Reassignment of Medicare Benefits" MLN Matters® Article - Released
- "Medicare Billing: 837I and Form CMS-1450" Fact Sheet - Revised
- "Medicare Billing: 837P and Form CMS-1500" Fact Sheet - Revised
- "Evaluation and Management Services Guide" Educational Tool - Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Product Available in Electronic Publication Format

## MLN Connects™ Provider eNews for November 26, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-11-26-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-11-26-eNews.pdf

***MLN Connects™ National Provider Calls***

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs - Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Certifying Patients for the Medicare Home Health Benefit - Register Now

***CMS Events***

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar - Reminder

***Announcements***

- In Observance of World AIDS Day - Remember HIV Screenings
- CMS Creates New Chief Data Officer Post
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Programs: Hardship Exception Applications due November 30
- New EHR Attestation Deadline for Eligible Hospitals: December 31

***Claims, Pricers, and Codes***

- Hospice Notices Returned to Provider
- MA Claims Issue for FQHCs that Bill Under the AIR System

***Medicare Learning Network® Educational Products***

- "Hospice Related Services - Part B" Podcast - Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Submit Your Feedback on the Medicare Learning Network® Learning Management System and Product Ordering System
- Medicare Learning Network® Product Available in Electronic Format



Customer Service should be your first means of contact for any questions or issues you have that cannot be addressed by the IVR. To speak with a Customer Service Representative directly call:

**866-590-6731**

# DME MAC Jurisdiction A Local Coverage Determinations

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

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

## ACA Requirement for Indicating Receipt Date of Documentation - Joint DME MAC Publication (GEN)

With the implementation of *Affordable Care Act* (ACA) Section 6407, there are local coverage determinations (LCDs) and related policy articles (PAs) that require suppliers to receive clinical documentation and orders within a specific period of time. According to these LCDs, "A date stamp or equivalent must be used to document receipt date." Documentation of the receipt date is a key requirement of these policies to demonstrate compliance with the statutory timeliness requirement.

Questions have arisen from suppliers about what methods are acceptable for documenting a receipt date. The DME MACs do not specify what method may be used to indicate date of receipt; however, there must be some indicator or notation on the documents that they were received by the supplier within the required time period. Some commonly accepted methods are hard-copy date stamps, hand-written dates, facsimile headers and electronic receipt dates. Regardless of the method used, it must be clear to contractor staff reviewing the claim that the date received meets the requirements in the applicable LCD.

*A cautionary note about utilizing facsimile headers to document receipt date.* Suppliers often rely on a fax header that includes a date and time indicator as an alternative to a date stamp. However, there are often multiple facsimile header lines that are the result of documents being faxed back and forth between the supplier and treating physician. Consequently, it is often difficult to determine the actual date of receipt of the documents by the supplier.

Suppliers should review their process for documenting the date of receipt of the documentation related to policies that require a receipt date. Suppliers must ensure that all documents clearly indicate the date that the documents were received. Suppliers who rely on fax header information should be especially vigilant to make sure that the receipt date is clearly indicated to avoid claim denials.

## Correct Coding - Cefaly® - Joint DME MAC Publication (SPE)

The Cefaly® device (Cefaly Technology) is a transcutaneous electrical nerve stimulator (TENS) that is applied to the forehead using a self-adhesive electrode positioned bilaterally over the upper branches of the trigeminal nerve. The Cefaly® device is intended to stimulate the upper branches of the trigeminal nerve and has received Food and Drug Administration (FDA) approval for the prophylactic treatment of episodic migraine headache.

Items that serve a prevention or precautionary purpose are non-covered by Medicare. The correct code for Cefaly® is:
A9270 - Noncovered item or service.

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.

## Correct Coding - Medicare Coverage for Shoes - Joint DME MAC Publication (SPE)

Medicare has limited coverage provisions for shoes used by beneficiaries. Section 1862(a)(8) of the *Social Security Act* (SSA) says:

> *[N]o payment may be made under part A or part B for any expenses incurred for items or services … where such expenses are for orthopedic shoes or other supportive devices for the feet, other than shoes furnished pursuant to section 1861(s)(12).*

SSA 1861(s)(12) describes coverage for, "extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes" when certain specified requirements are met. Reimbursement is available for shoes used by beneficiaries with diabetes when the applicable coverage requirements are met. The Therapeutic Shoes for Persons with Diabetes (TSD) Local Coverage Determination (LCD) and related Policy Article discuss these payment rules in detail.

In addition to TSD, payment may be possible for shoes that are an integral component of a brace. CMS Internet Only Manual 100-02, Chapter 15, Section 290.B states:

> *Orthopedic shoes and other supportive devices for the feet generally are not covered. However, **this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace.** (Emphasis added).*

These brace-related shoes are referred to as orthopedic footwear (ORF). Note that only the supplier of the brace may bill for payment for ORF in conjunction with claims for payment of the qualifying brace. Separate payment to a different supplier for shoes that are an integral component of a brace or for inserts and modifications to those shoes is not allowed. The Orthopedic Footwear LCD and related Policy Article address the applicable payment rules for these items.

There are situations where a beneficiary may qualify for both a diabetic shoe and a leg brace. CMS Internet Only Manual 100-02, Chapter 15, Section 140 says:

> ***In situations in which an individual qualifies for both diabetic shoes and a leg brace, these items are covered separately.** Thus, the diabetic shoes may be covered if the requirements for this section are met, while the brace may be covered if the requirements of §130 (Braces Benefit) are met. (Emphasis added).*

This means that the supplier of the TSD may bill separately for TSD while a different supplier may bill for the associated brace.

There are no other categories of shoes that are eligible for Medicare reimbursement.

Different sets of HCPCS codes are used to identify the shoes, modifications, and inserts that may be eligible for payment. Suppliers must be sure to use the correct codes for each group of products.

Only HCPCS A-codes are used for TSD and related items. Only L-codes are used for ORF. Both the TSD and ORF related Policy Articles address these points.

- From TSD Policy Article
  - *Codes for inserts or modifications (A5503-A5508, A5510, A5512, A5513) may only be used for items related to diabetic shoes (A5500, A5501). They must not be used for items related to footwear coded with codes L3215-L3253. Inserts and modifications used with L-coded footwear must be coded using L codes (L3000-L3649).**

- From ORF Policy Article
  - *Shoes, inserts, and modifications are covered in limited circumstances. They are covered in selected beneficiaries with diabetes for the prevention or treatment of diabetic foot ulcers. However, different codes (A5500-A5511) are used for footwear provided under this benefit. See the medical policy on Therapeutic Shoes for Persons with Diabetes for details.**

- *Depth-inlay or custom molded shoes for diabetics (A5500-A5501) and related inserts and modifications (A5503-A5511) are billed using these A-codes whether or not the shoe is an integral part of a brace. See the medical policy on Therapeutic Shoes for Persons with Diabetes for coverage, documentation, and additional coding guidelines.*
- *Oxford shoes that are an integral part of a brace are billed using codes L3224 or L3225 with a KX modifier. For these codes, one unit of service is each shoe. Oxford shoes that are not part of a leg brace must be billed with codes L3215 or L3219 without a KX modifier.*
- *Other shoes (e.g., high top, depth inlay or custom shoes for non-diabetics, etc.) that are an integral part of a brace are billed using code L3649 with a KX modifier. Other shoes that are not an integral part of a brace must be billed using codes L3216, L3217, L3221, L3222, L3230, L3251-L3253, or L3649 without a KX modifier.*

***Note:** Transferring or otherwise attaching a TSD to a brace is NOT considered a modification to the TSD. HCPCS code A5507 must not be used to bill for this service. See Orthopedic Footwear section (below) for additional information.

## Orthopedic Footwear

From the Nonmedical Necessity Coverage and Payment Rules section of the ORF Policy article:

*Shoes are also covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980-L2030, L2050, L2060, L2080, or L2090. Oxford shoes (L3224, L3225) are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for non-diabetics, etc. (L3649), are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600-L3640) involving shoes on a covered brace are also covered. Inserts and other shoe modifications (L3000-L3170, L3300-L3450, L3465-L3520, L3550-L3595) are covered if they are on a shoe that is an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Shoes and related modifications, inserts, heel/sole replacements or shoe transfers billed without a KX modifier will be denied as noncovered because coverage is statutorily excluded.*

*According to a national policy determination, a shoe and related modifications, inserts, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to a brace and items related to that shoe must not be billed with a KX modifier and will be denied as noncovered because coverage is statutorily excluded.*

*Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace. Shoes which are billed separately (i.e., not as part of a brace) will be denied as noncovered. A KX modifier must not be used in this situation.*

*Shoes are denied as noncovered when they are put on over a partial foot prosthesis or other lower extremity prosthesis (L5010-L5600) which is attached to the residual limb by other mechanisms because there is no Medicare benefit for these items.*

Refer to the LCDs, related Policy articles and the *Supplier Manual* for additional information about coverage, coding and documentation for these items.

For questions about correct coding, contact the Pricing, Data Analysis and Coding Contractor (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 at **https://www.dmepdac.com/contact/index.html**

## Correct Coding - MyoPro® (Myomo, Inc.) Assist Device - Joint DME MAC/PDAC Publication (MOB)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated the MyoPro® upper extremity assist device and determined that it falls within the Durable Medical Equipment (DME) benefit category. Claims for MyoPro® should be submitted using the DME miscellaneous code E1399.

Suppliers are reminded that when submitting claims for items coded E1399, the supplier must include the following information:

- Manufacturer name
- Model name or number
- Pricing information
- Explanation of medical necessity

This information must be entered in the narrative field of an electronic claim (NTE 2300 or NTE 2400 of an electronic claim) or Item 19 of a paper claim.

This item is classified under the capped-rental payment methodology as it does not meet the requirements to be categorized as an inexpensive or routinely purchased item.

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 at: **https://www.dmepdac.com/contact/index.html**

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## Correct Coding - Oral Anticancer Drugs and PDAC's NDC/HCPCS Crosswalk Listings - Joint DME MAC Publication (DRU)

Occasionally pharmaceutical manufacturers release drugs with NDCs and they do not immediately appear on the NDC/HCPCS crosswalk list maintained by the Pricing, Data Analysis and Coding (PDAC) contractor (see article from April 2013 entitled "Oral Anticancer Drugs - Coding and Billing Change"). This recently happened when Roxane Laboratories, Inc., a manufacturer of oral cyclophosphamide, discontinued their tablet forms of the drug and substituted capsules. Initially the capsule forms of the drug (NDC 00054-0382-25 for the 25 mg strength and NDC 00054-0383-25 for the 50 mg strength) were not on the NDC/HCPCS crosswalk list. This list has now been updated to reflect the new dosage forms and NDC numbers for Roxane's cyclophosphamide.

If a supplier bills an oral anticancer drug with an NDC number that is not on the NDC/HCPCS crosswalk list, the claim will receive a front-end reject by CEDI. To avoid this situation, suppliers should follow the instructions in the Coding Guidelines section of the Oral Anticancer Drugs related Policy Article (PA) which states:

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

Until a new NDC number is added to the list in the monthly update, suppliers have two options:

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

Claims submitted using code J8999 must include the name of the drug, the manufacturer, the NDC number, the dosage strength of each drug form (e.g., capsule, tablet, suppository, liquid) and the number of tablets or capsules dispensed. This information must be entered in the narrative field of an electronic claim (NTE 2300 or NTE 2400 of an electronic claim) or Item 19 of a paper claim.

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

## Correct Coding - Palatal Lift Prosthesis - Revision - Joint DME MAC Publication (O&P)

A palatal lift prosthesis is a dental appliance that is used to support the soft palate in individuals lacking the normal muscle function necessary to maintain the soft palate in its normal position.

Claims are occasionally submitted to the DME MACs using Not Otherwise Classified (NOC) HCPCS codes. When a specific code exists for any item, use of a NOC code is incorrect coding. The specific codes to be used on claims for a palatal prosthesis are:

D5955 - Palatal lift prosthesis, definitive
D5958 - Palatal lift prosthesis, interim
D5959 - Palatal lift prosthesis, modification

Current Dental Terminology (CDT) D codes are not within DME MAC jurisdiction. Claims for D codes must be submitted to the local carrier and should not be submitted to the DME MACs.

Claims for palatal lift prostheses must not be submitted to the DME MAC using HCPCS NOC (Not Otherwise Classified) codes.

## Correct Coding - Surgical Dressings Containing Medical Honey - DME MAC Joint Publication (SPE)

Medicinal use of honey has a long history with various health benefits ascribed to it. Recently the DME MAC Medical Directors requested information regarding the use of honey as a component in surgical dressings. We wish to thank all those who provided a response.

Historically medical honey has not been considered as a separate, covered surgical dressing component by Medicare. Dressings incorporating honey have been assigned HCPCS coding based upon the underlying covered elements. For example, an alginate dressing with honey is put into the same HCPCS codes as an alginate dressing without honey.

The DME MAC Medical Director Workgroup reviewed the clinical literature and other evidence in consideration of whether medical honey should be considered as a separate, covered component in surgical dressings. The workgroup determined that there is insufficient evidence to justify the conclusion that medical honey should be considered as a separate, covered component in surgical dressings. HCPCS coding for honey containing surgical dressings will continue as it has been in the past i.e. HCPCS coding is based upon the underlying covered components.

Refer to the Surgical Dressings Local Coverage Determination and related Policy Article for additional information about coverage and coding for surgical dressings.

## Coverage Reminder - External Infusion Pumps (EIP), Supplies, and Drugs - Joint DME MAC Publication (SPE)

A recent examination of CERT reviews for EIP claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

## Reasons for Denial

- Prescriptions
  - Physician's detailed written order is missing, incomplete, or invalid - 29%
- DME Information Form (DIF)
  - Missing DIF - 26%
- Reasonable & Necessary (R&N)
  - LCD Coverage Criteria not met - 39%
- Other
  - Continued Need Criteria not met - 3%
  - Unsigned Clinical Notes - 3%

## Payment Rules

***Prescriptions***

All items billed to Medicare require a prescription. A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS code E0784, as specified in the table contained in the Policy Specific Documentation Requirements Section of the LCD for External Infusion Pumps. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

***DME Information Form***

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request. The DIF for External Infusion Pumps is CMS Form 10125. The initial claim must include an electronic copy of the DIF.

If a beneficiary begins using an infusion for one drug and subsequently the drug is changed, another drug is added or if the code for a current drug changes, a Revised DIF must be submitted for use of the pump. The additional new or changed drug or the new HCPCS code for the existing drug must be listed along with all other drugs for which the pump is used should be included on the Revised DIF.

***Reasonable and Necessary (R&N) Criteria***

This policy covers numerous drugs, and suppliers and providers are encouraged to review the specific coverage requirements for the relevant drug in question. In general, external infusion pumps and related drugs and supplies will be denied as not reasonable and necessary when the criteria described by indication (I), (II), (III), (IV) or (V) in the LCD for External Infusion Pumps are not met. When an infusion pump is covered, the drug necessitating the use of the pump and necessary supplies are also covered.

When a pump has been purchased by the Medicare program, other insurer, the beneficiary, or the rental cap has been reached; the drug necessitating the use of the pump and supplies is covered as long as the coverage criteria for the pump are met.

Drugs are only covered as a supply to a covered DME infusion pump. Drugs billed alone (without a covered pump being used) will be denied as statutorily noncovered (no benefit).

***Continued Medical Need***

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

## Documentation

In the event of a claim review:

- Medicare requires that there is a prescription (order) for every separately billable item.
- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements are met.

This article presents a summary of the policy requirements related to the errors identified in the CERT reviews. The majority of reasons for CERT errors (55%) are completely within the purview of suppliers. Thus, suppliers are encouraged to review their claim submission practices, in order to begin to reduce the high level of CERT errors. There are additional requirements necessary for coverage that are not discussed in this article. Please refer to the LCD and related Policy article for complete information. Further education regarding this policy is available on your DME MAC contractor website.

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# Coverage Reminder - Negative Pressure Wound Therapy Devices (NPWT) - Revised - October 2, 2014 - Joint DME MAC Publication (SPE)

**Note:** *This is a revision to a previous version published in September 2014. It corrects an error in the "Prescriptions" requirement section that incorrectly referenced the Affordable Care Act (ACA) §6407 requirement for HCPCS code E2402. The ACA requirements do not apply to code E2402; however, code E2402 does require a written order prior to delivery.*

A recent examination of CERT reviews for NPWT claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

## REASONS FOR DENIAL

- Prescription Related
  - Referring physician's detailed written order missing - 9.09%
- Reasonable & Necessary (R&N) Related
  - Coverage criteria A not met - 63.64%
  - Coverage criteria B not met - 9.09%
  - Coverage criteria C not met - 9.09%
- Other
  - Beneficiary was in a Part A stay on date of service (DOS) - 9.09%

## PAYMENT RULES

***Prescriptions:***

All items billed to Medicare require a prescription. NPWT base code E2402 (NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE) requires that the prescription must meet the Written Order Prior to Delivery requirements.

***Reasonable and Necessary (R&N) Criteria:***

NPWT is only covered for certain types of wounds when other treatments have failed. The LCD specifies the following:

A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion A or B is met:

A. Ulcers and Wounds in the Home Setting:

The beneficiary has a chronic Stage III or IV pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT.

1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
   a. Documentation in the beneficiary's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
   b. Application of dressings to maintain a moist wound environment, and
   c. Debridement of necrotic tissue if present, and.
   d. Evaluation of and provision for adequate nutritional status

2. For Stage III or IV pressure ulcers:
   a. The beneficiary has been appropriately turned and positioned, and
   b. The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see LCD on support surfaces), and
   c. The beneficiary's moisture and incontinence have been appropriately managed

3. For neuropathic (for example, diabetic) ulcers:
   a. The beneficiary has been on a comprehensive diabetic management program, and
   b. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities

4. For venous insufficiency ulcers:
   a. Compression bandages and/or garments have been consistently applied, and
   b. Leg elevation and ambulation have been encouraged

B. Ulcers and Wounds Encountered in an Inpatient Setting:
   1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
   2. The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).

Coverage of NPWT ends when certain conditions occur. The LCD specifies:

C. For wounds and ulcers described under A or B above, once placed on an NPWT pump and supplies, in order for coverage to continue, a licensed medical professional must do the following:
   1. On a regular basis,
      a. Directly assess the wound(s) being treated with the NPWT pump, and
      b. Supervise or directly perform the NPWT dressing changes, and
   2. On at least a monthly basis, document changes in the ulcer's dimensions and characteristics.

## Documentation:

In the event of a claim review,

- Medicare requires that there is a prescription (order) for every separately billable item.
- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements are met.

## Durable Medical Equipment Provided During a Part A Stay:

Durable Medical Equipment (DME) is only covered when provided for use in the beneficiary's home. DME provided during a covered Part A stay is not eligible for separate reimbursement by the DME MACs.

This article presents a summary of the policy requirements related to the errors identified in the CERT reviews. There are additional requirements necessary for coverage that are not discussed. Refer to the LCD and related Policy article for complete information. Further education regarding this policy is available on your DME MAC contractor website.

## E1825, E1830 and E1831 and Use of Modifiers - Joint DME MAC Publication (GEN)

Effective for dates of service on or after January 1, 2015, devices coded with HCPCS code E1825 (Dynamic adjustable finger extension/flexion device, includes soft interface material) must use one of the following modifiers when billing this code:

| | |
|---|---|
| FA | Left hand, thumb |
| F1 | Left hand, second digit |
| F2 | Left hand, third digit |
| F3 | Left hand, fourth digit |
| F4 | Left hand, fifth digit |
| F5 | Right hand, thumb |
| F6 | Right hand, second digit |
| F7 | Right hand, third digit |
| F8 | Right hand, fourth digit |
| F9 | Right hand, fifth digit |

Effective for dates of service on or after January 1, 2015, devices coded with HCPCS Codes E1830 (Dynamic adjustable toe extension/flexion device, includes soft interface material) or E1831 (Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories) must use one of the following modifiers when billing these codes:

| | |
|---|---|
| TA | Left foot, great toe |
| T1 | Left foot, second digit |
| T2 | Left foot, third digit |
| T3 | Left foot, fourth digit |
| T4 | Left foot, fifth digit |
| T5 | Right foot, great toe |
| T6 | Right foot, second digit |
| T7 | Right foot, third digit |
| T8 | Right foot, fourth digit |
| T9 | Right foot, fifth digit |

Failure to append a modifier to claim lines with codes E1825, E1830 or E1831 will result in a claim rejection.

## Face-to-Face Requirements for Orders Used to Obtain Medicare Payment on ACA Items - Joint DME MAC Publication (GEN)

The *Affordable Care Act* (ACA) Section 6407 requires a face-to-face encounter to occur within 6 months prior to the written order prior to delivery (WOPD) for certain DME items listed within it (see "MM8304 Revised - *Detailed Written Orders and Face-to-Face Encounters*"). This requirement applies any time a new order has been obtained for the purposes of Medicare payment. The only exception to the requirement for a face-to-face encounter within 6 months is when a new order is obtained due to state law, and the order is **not** being used as documentation to support a claim for Medicare payment. If the order is being used to meet a Medicare requirement, a new face-to-face must be conducted.

If a new order is being used as documentation to support continued medical need or to fulfill any other documentation requirement for Medicare payment, then a face-to-face encounter within 6 months prior would be required. One way to determine whether or not a

new face-to-face encounter is required is to determine if the order obtained/required will be used to support Medicare payment of the claim. If the answer is "yes" then a face-to-face encounter is required within 6 months of the date prior to that order.

The face-to-face requirement became effective 7/01/2013 for all ACA items and a delay in enforcement has been made by the DME MACs. Other auditing entities may enforce this requirement at this time.

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## ICD-10 Updates to Local Coverage Determinations (LCDs) and Policy Articles (PAs) (GEN)

Local Coverage Determinations (LCDs) and related Policy Articles (PAs) have been updated and are displaying in the Medicare Coverage Database. To keep separate the ICD-9s from the ICD-10s, all ICD-10 LCDs and PAs (with and without diagnosis codes) have been assigned new ID numbers, and have an effective date of October 01, 2015.

The updated LCDs and PAs are available on the Medicare Coverage Database located on the CMS Web site at:
**http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntrctr=137&DocType=Future**

The Centers for Medicare & Medicaid (CMS) has determined that although new LCD numbers are assigned, the policies shall not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD.

For more information, CMS has dedicated a page to ICD-10 on **http://www.cms.gov**. This page is updated regularly, usually at least once per week, and houses resources, articles and products concerning ICD-10. Suppliers can check the latest news specific to ICD-10 as well as reference applicable Medicare Learning Network (MLN) publications. Follow this link to access the ICD-10 page:
**http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html**

The following list of LCDs and related PAs contain diagnoses that have been updated to ICD-10 codes.

| | |
|---|---|
| L33686 | Ankle-Foot/Knee-Ankle-Foot Orthosis |
| L33690 | Automatic External Defibrillators |
| L33317 | External Breast Prostheses |
| L33794 | External Infusion Pumps |
| L33822 | Glucose Monitors |
| L33785 | High Frequency Chest Wall Oscillation Devices |
| L33824 | Immunosuppressive Drugs - Policy Article |
| L33610 | Intravenous Immune Globulin - Policy Article |
| L33318 | Knee Orthoses |
| L33795 | Mechanical In-exsufflation Devices |
| L33370 | Nebulizers |
| A52479 | Oral Anticancer Drugs - Policy Article |
| A52480 | Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) - Policy Article |
| L33611 | Oral Appliances for Obstructive Sleep Apnea |
| L33641 | Orthopedic Footwear |
| L33796 | Osteogenesis Stimulators |
| L33828 | Ostomy Supplies - Policy Article |
| L33797 | Oxygen and Oxygen Equipment |
| L33718 | Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea |
| L33642 | Pressure Reducing Support Surfaces - Group 2 |
| L33692 | Pressure Reducing Support Surfaces - Group 3 |
| L33793 | Refractive Lenses |
| L33612 | Suction Pumps |
| L33369 | Therapeutic Shoes for Persons with Diabetes - Policy Article |
| L33832 | Tracheostomy Care Supplies - Policy Article |
| L33802 | Transcutaneous Electrical Nerve Stimulators (TENS) |

| | |
|---|---|
| L33803 | Urological Supplies |
| L34824 | Vacuum Erection Devices (VED) |
| L33312 | Wheelchair Seating |

## LCD and Policy Article Revision Summary for October 9, 2014 (SPE)

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

### Respiratory Assist Devices

***LCD***

Revision Effective Date: 12/01/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Definitions of Central Sleep Apnea and Complex Sleep Apnea to include a CAHI index and expands signs and symptoms that describe the conditions
Revised: Severe COPD to clarify that definitive testing is not necessary to exclude OSA when the clinical picture is sufficient
Revised: Severe COPD to clarify that nocturnal oximetry is a cumulative 5 minutes of testing
Revised: Hypoventilation Syndromes to remove FEV1
Revised: PSG testing to also include HST testing when used in the in-patient hospital setting to establish or rule out the diagnosis of OSA
Added: Ventilator section based upon NCD and April 2014 coding and coverage article
Added: Sleep Test coverage and payment rules

***Policy Article***

Revision Effective Date: 12/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 prescriber requirements

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

## LCD and Policy Article Revisions Summary for October 2, 2014 (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 LCDs and related PAs for complete information.

### External Infusion Pumps

***LCD***

Revision Effective Date: 11/01/2014
DOCUMENTATION REQUIREMENTS:
Removed: Suggested form for inotrope information

### Knee Orthoses

***LCD***

Revision Effective Date: 10/01/2014
COVERAGE INDICATIONS, LIMITATIONS, and/or MEDICAL NECESSITY:
Added: Codes K0901 and K0902 to Prefabricated Knee Orthoses section
Added: Base Codes K0901 and K0902 to Addition Codes tables

Added: Codes K0901 and K0902 to the requirement (1) for custom fabricated knee orthosis with an adjustable flexion and extension joint
HCPCS CODES:
Added: Codes K0901 and K0902
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: Codes K0901 and K0902 to Group 4 Codes

***Policy Article***
Revision Effective Date: 10/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Codes K0901 and K0902 to Correct coding of prefabricated knee orthoses
Added: Reasonable Useful Lifetime for codes K0901 and K0902
CODING GUIDELINES:
Added: Codes K0901 and K0902 to coding guidelines
Added: Base Codes K0901 and K0902 to Addition Codes table

### Therapeutic Shoes for Persons with Diabetes

***Policy Article***
Revision Effective Date: 11/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Criterion 5 (in-person fitting requirement)

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

## Pneumatic Compression Devices (PCD) - Response to Comments Summary (SPE)

### Preamble

When the DME Contractor Medical Directors published the Proposed LCD for Pneumatic Compression Devices (PCDs) in 2011, there had been a period of several years when we had regularly received requests for coverage of PCDs for peripheral arterial disease from a number of those treating these conditions, indicating the technology and its acceptance had significantly advanced and was becoming more generally accepted. Those at the DME Open Public Meeting supported this position. In the interval since that time, however, in more closely reviewing the public positions and guidelines from nearly all of the major cardiovascular and surgical societies, support for the use of this technology is not found, even for limited use. For this reason we are not at this time adding routine coverage for PCDs for arterial disease.

1. Multiple commenters supported the extension of coverage of Pneumatic Compression Devices (PCDs) to include those for Peripheral Arterial Disease (PAD). Several commenters took the position that the LCD should include coverage of PCDs for *all* PAD, and not be restricted to those who would otherwise qualify for a surgery but were medically ineligible.

   **Response:** This final policy does not allow for coverage of Pneumatic Compression Devices (PCDs) for Peripheral Arterial Disease (PAD) of any severity. Further literature searches since the date of the draft release have shown no long-term studies supporting that outcomes using a PCD are comparable to the accepted standard of using a surgical revascularization where possible and no major cardiovascular or surgical societies have adopted guidelines taking this position. We received limited journal copies, anecdotal case-reports and brief series information to support the use of this technology as a temporizing or supportive measure for those with advanced disease who are otherwise ineligible for surgery, but here as well, there are no sizeable, long-term studies of efficacy. The medical directors extensively again reviewed all submitted literature as well as coverage decisions by major agencies, health service research entities and insurers (see in the LCD under **Sources of Information and Basis for Decision**). Of these, *only* *one*, from Ireland's Health Information and Quality Authority takes a position supporting any coverage, and that is equivocal, indicating "...more research is needed to confirm...a *potentially* beneficial treatment for people at risk of amputation who are not candidates for revascularization...remains unproven." After this

reassessment, we have concluded it is not reasonable and necessary to add coverage of arterial peripheral compression devices (E0675) at this time.

2. Multiple commenters suggested diagnostic findings and tests that in their opinion could confirm eligible beneficiaries for PCDs for PAD as a possible alternative to attestation that the beneficiary would otherwise be a candidate for surgery.

   **Response:** There was little consistency to these recommendations. Had we pursued coverage of arterial compression at this time, we would have needed to continue the "otherwise be a candidate for surgery" criterion. Currently, there is no consensus on the usefulness of available diagnostic tests to demonstrate the predictive value of arterial PCD.

3. Several commenters recommended allowing coverage of an E0652 PCD for secondary lymphedema of any etiology, with or without ulcers, when diagnostic criteria are met and the E0650 or E0651 has been ineffective at controlling the lymphedema. It was recommended that documentation of trained and supported daily use of a carefully fitted E0650 or E0651 for a minimum of 4 weeks without significant clinical response should be sufficient to evidence the need for the E0652 device. It was recommended the documentation include a detailed description of the therapies recommended in conjunction with the pump as well as providing objective clinical details of why E0650/E0651 device and adjunct therapies were not effective.

   **Response:** The CMS National Coverage Decision (280.6) has determined, "The only time that a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber."

   Review of the clinical literature indicates that the *only* consistently documented clinical need for an E0652 is for the treatment of lymphedema extending onto the chest, trunk and/or abdomen past the limits of a standard compression sleeve, where the lymphedema has failed to improve with a continued, carefully-performed, good-faith trial of the E0650/E0651 device coupled with other more conservative therapy.

Commenters indicated a need to use an E0652 where an E0650/E0651 was simply incapable of the task due to conditions of severe obesity, chronicity, fibrosis, number of wounds or other reasons, but there was no literature provided to enable a systematic way to identify these rare situations. The absence of such clinical literature prevents development of criteria to identify individual clinical circumstances and they must therefore continue to be addressed at appeal by individual consideration of a record which must establish that all other more conservative approaches including the continuous, regular use of E0650/E0651 over time have proven insufficient, whereas a trial of the E0652 has been successful.

4. Several commenters raised a concern that the draft LCD conflicts with NCD 280.6 for PCDs by being more restrictive that the NCD in the coverage afforded to causes of lymphedema.

   **Response:** The revised LCD broadens the allowed indications and thereby specifically addresses any concern in this area. There is no conflict with the revised LCD and the NCD.

5. One commenter recommended that an inability to tolerate compression bandaging for venous ulcers should be an immediate indication for venous compression regardless of the length of time the ulcers have been present.

   **Response:** This is not an option for the DME MACs under NCD 280.6.

6. One commenter recommended that the six-month period of conservative therapy for venous stasis ulcers be reduced to four months. Other commenters also objected to the six-month requirement.

   **Response:** This is not an option for the DME MACs under NCD 280.6.

7. Several commenters recommended that PCDs should be covered for chronic venous insufficiency even in the absence of ulcers.

   **Response:** This is not an option for the DME MACs under NCD 280.6. However, the coverage of lymphedema from various causes has been broadened which will likely accomplish much of what these commenters desire.

8. One commenter felt the language "*...has failed to improve with a period of at least four weeks of regular daily home use of the E0650 or E0651 with careful, in-person fitting, overview and training by a technician skilled in and regularly, successfully using the appliances prescribed.*." is unclear.

   **Response:** The language and formatting have been clarified.

9. One commenter recommended that an E0652 be allowed for unilateral limb edema, documented to be unresponsive to use of E0651/E0650 coupled with other more conservative measures, on a prior authorization basis.

   **Response:** This recommendation is beyond the scope of the current LCD and Policy Article revisions.

10. One large manufacturer of PCDs recommended that part of the current focus in the NCD and LCD about usage of the E0650 and E0651 was because of price differential and that with improvements in technology and cost-efficiencies in recent years, Medicare should reduce the reimbursement for E0652 and relax requirements for use of this code.

    **Response:** This recommendation is beyond the scope of the current LCD and Policy Article revisions.

11. Quite a number of commenters had recommendations and/or concerns about the rapidity and duration of inflation and deflation times for arterial compression devices, indicating these are critical variables in their functional efficacy and that a number of the products on the market seeking coverage do not have comparable functional efficacy. Others had concerns that the manufacturing requirements for arterial compression devices were not adequately addressed, including a number of very detailed and well-documented observations, reports of research on various parameters and peer-reviewed articles on these topics

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

12. Multiple commenters objected to the requirement that the ordering of an E0675 was being restricted to a vascular surgeon.

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

13. Several commenters pointed out that angiographic dye may be contraindicated in some patients and therefore alternative diagnostic methods for severity of arterial disease are necessary.

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

14. Several commenters offered recommendations and/or concerns about the recertification of the need for PCDs for arterial compression.

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

15. Several commenters indicated podiatrists should be an eligible provider type to order PCDs, rather than have ordering providers limited to physicians (MD, DO) and physician extenders (NP, PA & CNS).

    **Response:** Podiatrists (DPM) and other providers are excluded because applicable state scope-of-practice or other license requirements limit management of systemic conditions. Treatment of peripheral artery disease, lymphedema, chronic venous insufficiency with ulceration and complications related to the treatment of these conditions by use of PCDs, require consideration of diagnoses and management of systemic conditions that fall outside of these practitioners' license limitations.

16. One commenter indicated PCDs are very effective in his vascular surgery practice without needing to use or try more conservative measures first and on that basis they should be a first-line therapy for this condition.

    **Response:** The Medical Directors disagree. Many therapies and testing modalities *may* be effective for conditions which would otherwise respond to simpler, conservative measures. The logic of medical necessity indicates that such interventions should be used in series, first using simpler measures shown by accepted clinical practice to often be effective, unless there is a clear evidence basis to skip these simpler measures for the specific clinical circumstances.

17. One commenter pointed out the word “endoscopic” should be changed on page four.

    **Response:** We agree. The language has been changed.

18. Two commenters pointed out that the CMN for pneumatic compression pumps, CMS Form 846 (DME Form 04.04B), does not track with the NCD and LCD requirements which causes confusion in submitting claims.

    **Response:** We agree and are hopeful the CMN may at some point be revised to correct these issues, but this is currently beyond the scope of this LCD and Policy Article revision.

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## Pneumatic Compression Devices LCD - Implementation Delayed - Joint DME MAC Publication (SPE)

The Pneumatic Compression Devices Local Coverage Determination (LCD) and related Policy Article (PA) scheduled to take effect for dates of service on or after November 1, 2014 are being delayed. Additional clinical information published since the release of the draft policy is being reviewed. No future effective date for the draft policy is available at this time. The current LCD and related PA will remain in effect.

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## Policy Article Revision - Vacuum Erection Devices (VED) - Joint DME MAC/PDAC Publication (O&P)

The DME MACs have revised the Coding Guidelines in the related Policy Article for Vacuum Erection Devices (VED). The current Coding Guidelines state:

> *Vacuum pumps typically draw a vacuum of less than 17 inches of mercury. If the vacuum range of a new device differs by more than +/- 10% from that specification, manufacturers must conduct studies to establish the clinical safety and efficacy of the vacuum drawn by their device. The manufacturer must perform tests to verify the maximum vacuum level.*
>
> *All devices coded L7900 for reimbursement by Medicare must include a vacuum limiter such that a maximum vacuum of less than or equal to 17 inches of mercury is obtained unless manufacturers demonstrate via clinical studies establishing the clinical efficacy of the vacuum drawn by their device.*

The revised Coding Guidelines state:

> *Vacuum pumps coded L7900 must demonstrate a capability to generate a negative pressure in the range of greater than 3.9 and less than 17 inches of mercury (100 and 432 mmHg, respectively). All devices coded L7900 for reimbursement by Medicare must include a vacuum limiter such that a maximum vacuum of less than 17 inches of mercury (432 mmHg) is obtained. The manufacturer must perform tests to verify the maximum vacuum level.*

The DME MACs will be publishing this revised language in an upcoming revision of the policy.

As a reminder, effective for dates of service on or after 11/01/2014, only products that have been reviewed by the Pricing, Data Analysis and Coding (PDAC) contractor and assigned code L7900 and L7902 are reimbursable by Medicare. Products which have not undergone coding verification review by the PDAC must be coded A9270. The revised Coding Guideline product specifications will be applied to products submitted for review.

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 at **https://www.dmepdac.com/contact/index.html**

## 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 56.4%. A summary of findings was published on the NHIC, Corp. Website on July 24, 2014. Based on this result, a widespread prepayment review was continued.

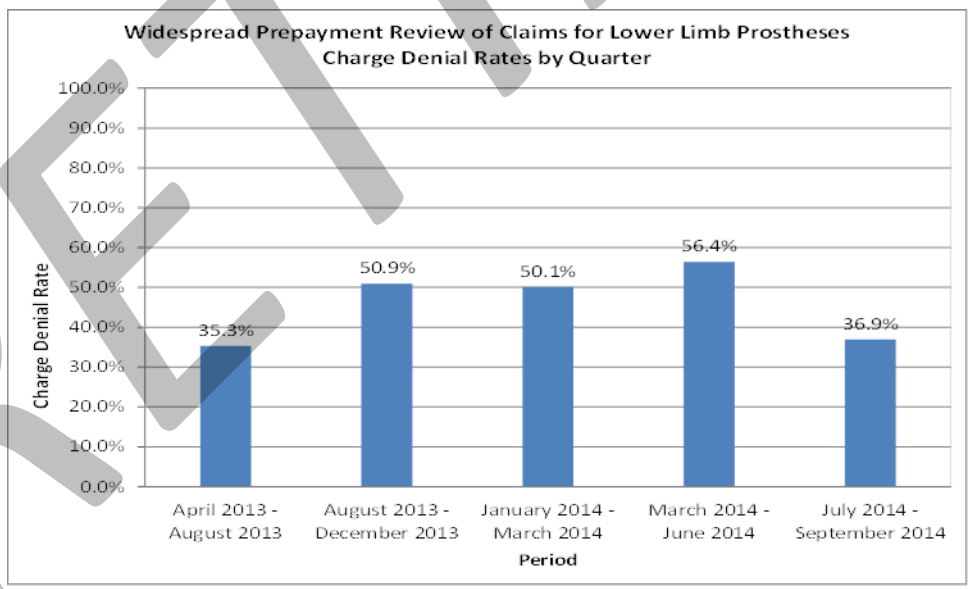
### Current Review Results

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 263 claims submitted by 155 suppliers for claims processed June 12, 2014 to September 22, 2014. Responses to the Additional Documentation Request (ADR) were not received for 34 (13%) of the claims. For the remaining 229 claims, 128 claims were allowed and 101 were denied resulting in a claim denial rate of 44%. 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 36.9%.

### Charge Denial Rate Historical Data

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




### Reasons for Denial

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

***Lack of Medical Record Documentation***

- 17.6% of the denied claims had no medical record information submitted.

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

- 9.6% of the denied claims had clinical records submitted but the records did not justify the functional level of the billed item.

***Proof of delivery***

- 4.2% of the denied claims were missing the Proof of Delivery. Proof of Delivery was missing items delivered; items must be documented with a narrative description or a manufacturer name and model number.

## Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC, Corp. 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 dispensed, treating physician's signature and date, and the start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed; and the prosthetist's evaluation/assessment documentation detailing the functional levels of the 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.

**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; Proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed; The prosthetist's evaluation/assessment and clinical documentation detailing the functional levels of the items billed; Clinical documentation to support functional level of the device and to corroborate the prosthetist's records.

Missing: Documentation in the Detailed Written Order or clinician notes that state why items are being replaced.

**Example 3:**

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the evaluation/assessment documentation for the functional level of item(s) billed, which details the functional level of the items billed.

Missing: Clinical documentation to support functional level of the device and to corroborate the prosthetist's records, proof of delivery was also missing, which validates that the beneficiary received the items that were billed.

## Next Step

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

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

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

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

## Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**
- The *DME MAC Jurisdiction A Supplier Manual* - Chapter 10: Includes Standard Documentation Requirements
  **http://www.medicarenhic.com/dme/supmandownload.aspx**
- Dear Physician Letter - Documentation of Artificial Limbs
  **http://www.medicarenhic.com/dme/mobile/index.html**
- CERT Errors (Monthly Publications)
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (Posted October 25, 2013; January 21, 2014; April 24, 2014; July 24, 2014.)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**
- Results of Widespread Prepayment Probe for Lower Limb Prostheses (Posted November 30, 2011)
  **http://www.medicarenhic.com/viewdoc.aspx?id=353**

# Results of Widespread Prepayment Probe for Milrinone (J2260) (DRU)

## Probe Review Results

This is the first DME MAC A Medical Review probe for Milrinone, HCPCS code J2260. This probe was initiated due to an increase in billing identified by data analysis.

## Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment probe review of claims for Milrinone, HCPCS code J2260.

The review involved prepayment complex medical review of 152 claims submitted by 30 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 12 (8%) of the claims. For the remaining 140 claims, 12 claims were allowed (9%) and 128 were denied/partially denied resulting in a claim denial rate of 91%. 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 86.6%.

## Primary Reasons for Denial

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

### *Clinical Documentation Issues*

- 2% of the denied claims were missing clinical information to support medical necessity.
  - No medical records were submitted

- 71% of the denied claims did not meet all eight coverage criteria as listed in the External Infusion Pumps LCD (L5044):
    1. Dyspnea at rest or with minimal exertion is present despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g., hydralazine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant), and
    2. Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):
        i. Dobutamine - - 2.5-10 mcg/kg/min
        **ii. <u>Milrinone - - 0.375-0.750 mcg/kg/min</u>**
        iii. Dopamine - - less than or equal to 5 mcg/kg/min, and
    3. Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), performed within 6 months prior to the initiation of home inotropic therapy showing (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b)at least a 20% increase in CI and/or at least a 20% decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion, and
    4. There has been an improvement in beneficiary well being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly, and
    5. In the case of continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in the hospital, or in the case of intermittent infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management, and
    6. Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home, and
    7. The beneficiary is maintained on the lowest practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first 3 months of therapy, and
    8. The beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy are routinely assessed and documented in the beneficiary's medical record.

***<u>Detailed Written Order</u>***

- 2% of the denied claims were missing the detailed written order.
- 26% of the denied claims had an incomplete or invalid detailed written order. The following are specific issues identified:
    - Missing a start date
    - Missing the frequency of use
    - Missing the route of administration
    - Missing the number of refills

***<u>Proof of Refill Request Issues</u>***

- 51% of the denied claims were missing a proof of refill
- 1% of the denied claims had an incomplete or invalid proof of refill
    - Missing documentation demonstrating that supplies are nearly exhausted

***<u>Proof of Delivery Issues</u>***

- 6% of the denied claims were missing proof of delivery
- 45% of the denied claims had an incomplete or invalid proof of delivery. The following are specific issues identified:
    - Unable to associate the supplier proof of delivery records to a delivery service record (Method II)
    - Milrinone delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier(Method I)
    - Milrinone shipped either before or after the date of service of the claim when the item is shipped via a shipping service or delivery service (Method II) directly to a beneficiary
    - The amount of drug billed was more than the amount of drug that was delivered
    - The quantity billed was higher than the quantity delivered.

***<u>DME Information Form (DIF) issues</u>***

- 2% of the denied claims were missing a DIF
- 1% of the denied claims had an invalid or incomplete DIF

## 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 milrinone (J2260) claims:

**Example 1:**

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and/or start date, detailed description of the item, treating physician's signature and date, dosage concentration, quantity to be dispensed, number of refills; clinical documentation that showed dyspnea at rest or with minimal exertion despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator; milrinone doses were within the range of 0.375-0.75 mcg/kg/min; Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), were performed within 6 months prior to the initiation of milrinone showing (a) cardiac index (CI) was less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) was greater than or equal to 20 mm Hg before milrinone infusion on maximum medical management and (b) at least a 20% increase in CI and/or at least a 20% decrease in PCWP during milrinone infusion at the dose initially prescribed for home infusion; improvement in beneficiary well being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly; there was documented deterioration in clinical status when milrinone was tapered or discontinued under observation in the hospital; life threatening arrhythmias (if any were noted) were controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home; the beneficiary was maintained on the lowest practical dose and efforts to decrease the dose of milrinone were documented or the frequency/duration of infusion were documented during the first 3 months of therapy; the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record; proof of refill request; proof of delivery; and a completed DIF.

Missing: The frequency of use and the route of administration on the detailed written order.

**Example 2:**

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and start date, detailed description of the item, treating physician's signature and date, dosage concentration, route of administration, frequency of use, quantity to be dispensed, number of refills; clinical documentation that showed dyspnea at rest or with minimal exertion despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator; milrinone doses were within the range of 0.375-0.75 mcg/kg/min; cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), were performed within 6 months prior to the initiation of milrinone showing (a) cardiac index (CI) was less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) was greater than or equal to 20 mm Hg before milrinone infusion on maximum medical management and (b) at least a 20% increase in CI and/or at least a 20% decrease in PCWP during milrinone infusion at the dose initially prescribed for home infusion; improvement in beneficiary well being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly; there was documented deterioration in clinical status when milrinone was tapered or discontinued under observation in the hospital; life threatening arrhythmias (if any were noted) were controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home; proof of refill request; proof of delivery; and a completed DIF.

Missing: The clinical documentation did not show that the beneficiary was maintained on the lowest practical dose and efforts to decrease the dose of the drug were documented or the frequency/duration of infusion were documented during the first 3 months of therapy; the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record.

**Example 3:**

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and start date, detailed description of the item, treating physician's signature and date, dosage concentration, route of administration, frequency of use, quantity to be dispensed, number of refills; clinical documentation that showed the beneficiary was maintained on the lowest practical dose and efforts to decrease the dose of the drug were documented or the frequency/duration of infusion were documented during the first 3 months of therapy; the beneficiary's cardiac symptoms,

vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record; proof of delivery; and a completed DIF.

Missing: There was no clinical documentation submitted from when the beneficiary initiated the milrinone therapy, therefore the documentation did not show dyspnea at rest or with minimal exertion despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator; Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), were performed within 6 months prior to the initiation of milrinone showing (a) cardiac index (CI) was less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) was greater than or equal to 20 mm Hg before milrinone infusion on maximum medical management and (b) at least a 20% increase in CI and/or at least a 20% decrease in PCWP during milrinone infusion at the dose initially prescribed for home infusion; improvement in beneficiary well being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly; there was documented deterioration in clinical status when milrinone was tapered or discontinued under observation in the hospital; life threatening arrhythmias (if any were noted) were controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home. No proof of refill submitted. Unable to associate the supplier proof of delivery records to a delivery service record.

## Next Step

Based on the results of this prepayment review, DME MAC A will continue with a prepay complex widespread medical review of claims for Milrinone, HCPCS J2260.

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

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

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

## Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for milrinone 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.

- External Infusion Pumps LCD (L5044) and Policy Article (A19713)
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

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

- Live Line Chat Webinars
  **http://www.medicarenhic.com/dme/rcseminars.aspx#liveline**

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

## Historical Review Results

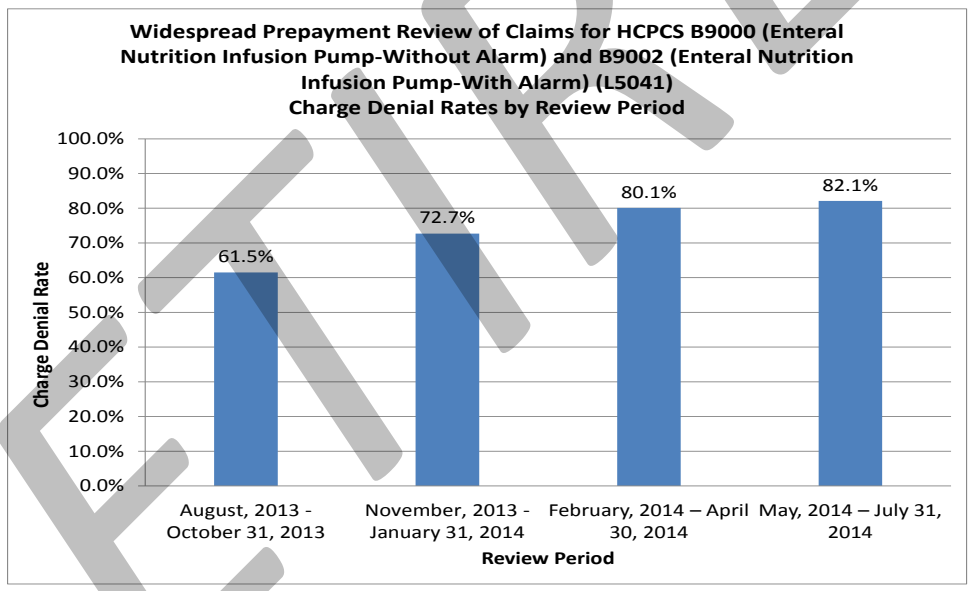
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed February 1, 2014 through April 30, 2014 and resulted in 80.1% Charge Denial Rate (CDR).

## Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 and B9002. These findings include claims processed primarily from May 1, 2014 through July 31, 2014.

The review involved prepayment complex medical review of 950 claims submitted by 101 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 269 (28%) of the claims. For the remaining 681 claims, 125 claims were allowed and 564 were denied/partially denied resulting in a claim denial rate of 82%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 82.1%.

## 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. Also note that claims can be denied for multiple reasons therefore the percentages of reviews may not add up to 100%.

### *Clinical Documentation Issues*

- 25% of the denied claims did not have any medical record documentation submitted.
- 16% claims had insufficient clinical documentation to justify the LCD criteria.
  **Note:** *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 2% of the claims denied for statutory denial did not meet prosthetic benefit requirement. Beneficiary able to tolerate oral nutrition.

***Proof of Delivery***

- 27% of the denied claims had no Proof of Delivery (POD).
- 18% of the claims had incomplete delivery information.
  - No proof of receipt by the beneficiary.
  - Unable to match and verify through name, use of order numbers, and/or conflicting tracking numbers.

***Detailed Written Order Issues***

- 29% of the denied claims had missing detailed written orders.
- 11% of the denied claims had incomplete detailed written orders.
  - Date of the detailed order was incomplete (missing month or year)
  - Physician signature could not be authenticated

***DME Information Form***

- 9% missing DME Information Form
- 1% missing Enteral Pump HCPCS code

## 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: Detailed physician order, DIF, medical documentation, delivery ticket with signature and date.
Missing: Unable to authenticate physician's signature on supplier generated detailed order, no date of the signature.

**Example 2:**

Received: Detailed physician order, DIF, delivery ticket with signature and date.
Missing: Medical documentation that supports diabetic enteral formula and pump.

**Example 3:**

Received: Medical documentation that supports the prosthetic benefit.
Missing: Physicians detailed written order, DIF, delivery ticket.

## Next Step

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

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

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

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

## Educational References:

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

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

- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (Posted 06/23/2013; 03/08/2013; 07/20/2012; 05/11/2012; 12/22/2012; 09/20/2011 and 03/11/2011)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

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

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

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

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

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

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

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

### Historical Review Results

DME MAC A Medical Review continues to review E0570 (Nebulizer with Compressor), based on the results of previous quarterly findings. The previous quarterly findings covered the period of February 1, 2014 through April 30, 2014 and resulted in a Charge Denial Rate (CDR) of 62%.

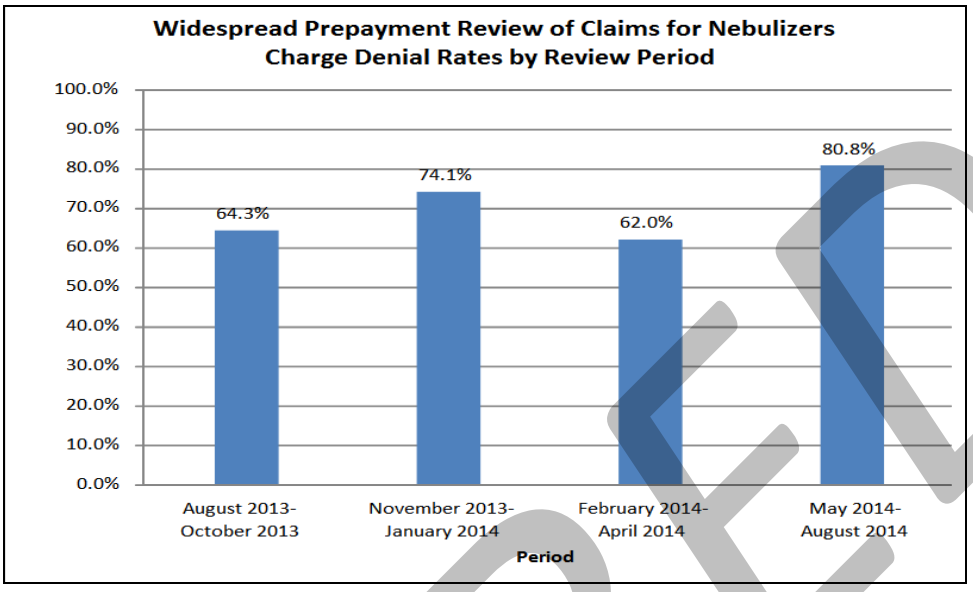
### Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from May 1, 2014 through August 31, 2014. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 2,282 claims submitted by 606 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 490 (21%) of the claims. For the remaining 1792 claims, 132 claims were allowed (7%) and 1,660 were denied/partially denied resulting in a claim denial rate of 93%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate (CDR) of 80.8%.

## Charge Denial Rate Historical Data

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




## Reasons for Denial

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

### *Clinical Documentation Issues*

- 19% of the denied claims were missing clinical information to support medical necessity.
  - No medical records were submitted
- 20% of the denied claims had insufficient or incomplete clinical documentation.
  The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer
    - Clinical documentation submitted did not mention a payable medical condition
    - Clinical documentation submitted had no mention of need for a nebulizer
  - Illegible copy of documentation submitted
  - Physician signature did not meet signature requirements including:
    - Missing physician's handwritten or electronic signature
    - Illegible physician signature with no printed name to verify against and no signature log submitted
    - Unsigned typed note with just physician's typed name

### *Written Order Prior to Delivery (WOPD)*

- 2% of the denied claims were missing the written order prior to delivery.
- 73% of the denied claims had an incomplete or invalid written order prior to delivery.
  The following are specific issues identified:
  - Missing the Physician's NPI number
  - Physician signature date was after the supplies were delivered
  - Insufficient evidence (i.e. date stamp, fax date, etc.) within the documentation to show that the supplier received the Written Order prior to delivering the supplies
  - Incompatible combination of items ordered

### *Proof of Delivery Issues*

- 3% of the denied claims were missing proof of delivery.
- 16% of the denied claims had an incomplete or invalid proof of delivery.
  The following are specific issues identified:

- Illegible copy of proof of delivery
- Missing sufficiently detailed description to identify the item(s) being delivered
- Missing beneficiary (or designee) signature when item(s) are delivered directly by the supplier to the beneficiary
- Nebulizer (first month rental) delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier(Method I)
- Nebulizer (first month rental) shipped either before or after the date of service of the claim when the item(s) is shipped via a shipping service or delivery service (Method II) directly to a beneficiary

## Claim Examples

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

**Example 1:**

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature, physician's NPI number, clinical notes and proof of delivery
Missing: Incompatible combination of nebulizer supplies ordered on the WOPD. Insufficient evidence (i.e. Date stamp, fax date, etc.) within the documentation submitted to show that the supplier received the WOPD prior to delivering the supplies. Proof of delivery missing a sufficiently detailed description (e.g., brand names, serial number, narrative description) of an E0570 nebulizer compressor.

**Example 2:**

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature, physician's NPI number, sufficient fax stamp that shows supplier received the WOPD before the items were delivered and clinical notes.
Missing: Clinical notes do not explain reasonable and necessary use of a nebulizer. Missing a proof of delivery.

**Example 3:**

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature, clinical notes and proof of delivery
Missing: The WOPD is missing the physician's NPI number. The date of the physician's signature on the WOPD is dated after the supplies were delivered. Insufficient evidence (i.e. Date stamp, fax date, etc.) within the claim submitted to show that the supplier received the WOPD prior to delivering the supplies.

## Next Step

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

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

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

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

## Educational References

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

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective July 2013 (A24944)
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- Results of Widespread Prepayment Review of Claims for E0570 (Posted September 13, 2013; December 12, 2013; March 20, 2014; June 26, 2014)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

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

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

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

- Face-to-Face and Written Order Requirements for High Cost DME - Dear Physician Letter
  **http://www.medicarenhic.com/dme/mobile/index.html**

## Results of Widespread Prepayment Review for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277) (MOB)

### Historical Review Results

The previous quarterly findings covered the period from January 1, 2014 through March 31, 2014 and resulted in a 73.9% Charge Denial Rate (CDR).

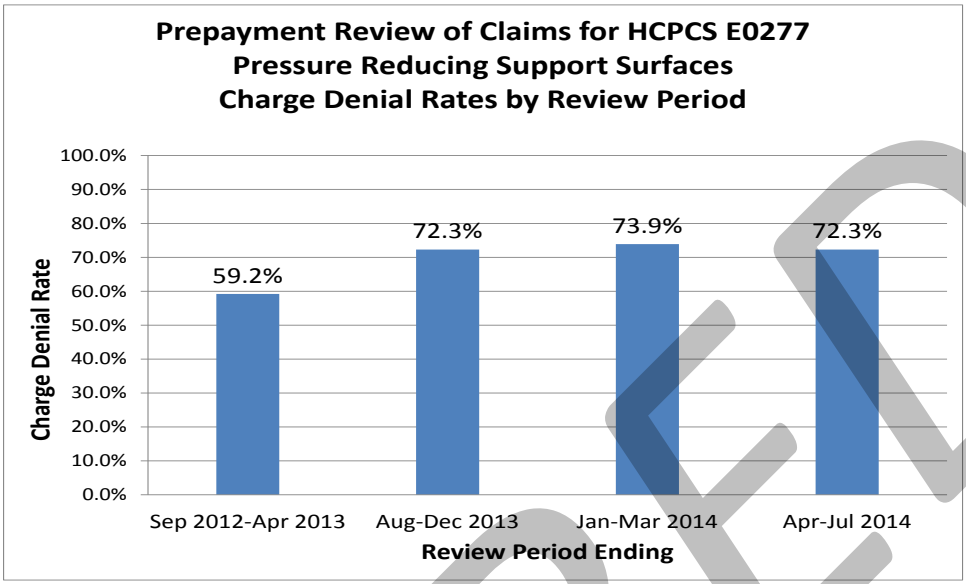
### Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277). These findings include claims with dates processed from April 1, 2014 through June 30, 2014. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 215 claims submitted by 72 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 47 (23%) of the claims. For the remaining 168 claims, 48 claims were allowed and 120 were denied resulting in a claim denial rate of 71%. 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 72.3%.

## 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.

### *Medical Documentation*

- 61% of the denied claims did not meet one or more of the three coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, or.
    2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
- 4% of the denied claims did not include medical documentation.
- 2% of the denied claims contained medical documentation that was illegible.
- 2% of the denied claims contained medical records that were not signed by the author.

### *Detailed Written Order*

- 6% of the denied claims did not include a narrative description or a brand name/model number of the item being dispensed.
- 3% of the denied claims contained a detailed written order that was dated after delivery.
- 2% of the denied claims were missing a detailed written order.

### *Proof of Delivery Issues*

- 9% of the denied claims contained proof of delivery that had a delivery date that was different than the date of service.
- 6% of the denied claims contained proof of delivery that was not signed by the beneficiary or designee.
- 4% of the denied claims did not include proof of delivery.
- 2% of the denied claims contained a proof of delivery that did not have a sufficiently detailed description in order to identify the item(s) being delivered.

### *Claim History Issues*

- 4% of the denied claims had a same/similar item in Medicare history records.

## 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 Group 2 Pressure Reducing Support Surface claims:

**Example 1**

Received:

- A detailed written order which includes the beneficiary's name, all options and accessories that will be billed separately or which require an upgraded code, signature of the treating physician and the date the order is signed and initial date of need or start date;
- Medical records from outpatient visits.

Missing:

- A detailed written order that did not include a detailed description of the item being ordered.
- The hospital medical records did not contain enough information to determine that the beneficiary met the coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, or
    2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
- The documentation submitted for review does not include a proof of delivery.

**Example 2**

Received:

- A detailed written order which includes the beneficiary's name, all options and accessories that will be billed separately or which require an upgraded code, signature of the treating physician and the date the order is signed and initial date of need or start date;
- Medical records consisting of wound clinic notes;
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:

- The supplier submitted a detailed written order that did not include a detailed description of the item being ordered.
- The wound clinic notes did not contain enough information to determine that the beneficiary met the coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program,
    2. the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
- The proof of delivery did not contain a sufficiently detailed description to identify the item being delivered.

**Example 3**

Received:

- A detailed written order which includes the beneficiary's name, detailed description of item being ordered, all options and accessories that will be billed separately or which require an upgraded code, signature of the treating physician and the date the order is signed and initial date of need or start date;
- Medical records consisting of hospital wound care notes;
- Proof of delivery which includes the beneficiary's name, delivery address, sufficiently detailed description to identify the item being delivered, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:

- The hospital wound care notes did not contain enough information to determine that the beneficiary met the coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program,
    2. the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

## Next Step

Based on the results of this prepayment review, DME MAC A will continue with a prepay complex widespread medical review of claims for Group 2 Pressure Reducing Support Surfaces, HCPCS E0277.

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

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

## Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for Group 2 Pressure Reducing Support Surfaces claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- LCD for Pressure Reducing Support Surfaces - Group 2 (L5068)
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- Hospital Beds with Mattresses, Group I and Group II Support Mattresses
  **http://www.medicarenhic.com/viewdoc.aspx?id=190**

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

- Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces
  **http://www.medicarenhic.com/viewdoc.aspx?id=2311**

- Results of Widespread Prepayment Complex Medical Review for Group 2 Pressure Reducing Support Surfaces (Posted 02/25/2014; 05/29/2014)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

- Complying with Medicare Signature Requirements
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf**

# Results of Widespread Prepayment Review for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277) (MOB)

## Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. 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 is the Charge Denial Rate (CDR). The previous quarterly findings covered the period from April 1, 2014 through June 30, 2014 and resulted in a CDR of 72.3%.

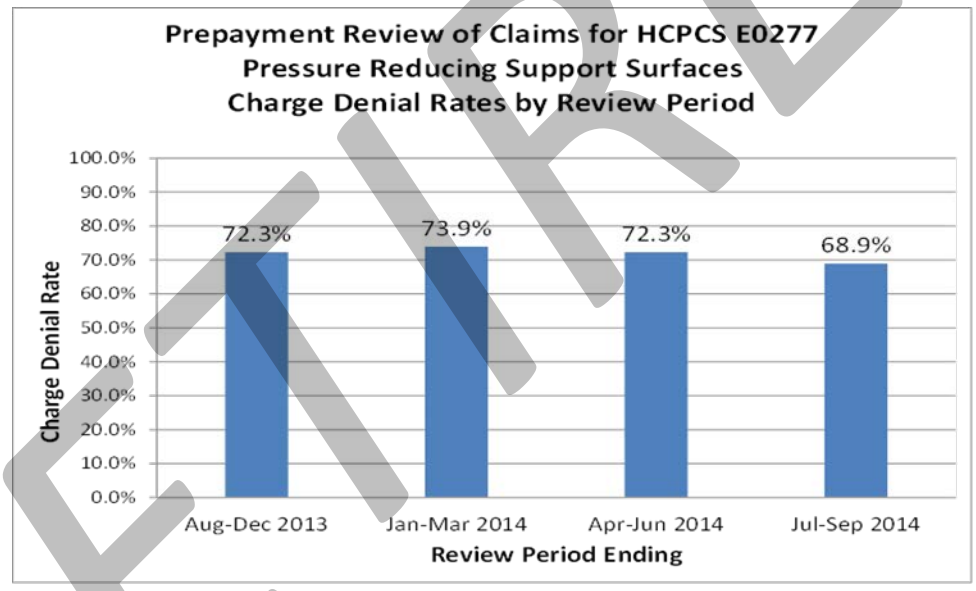
## Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277). These findings include claims with dates processed from July 1, 2014 through September 30, 2014.

The review involved prepayment complex medical review of 140 claims submitted by 46 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 64 (45%) of the claims. For the remaining 76 claims, 25 were allowed and 51 of the claims were denied. This resulted in a claim denial rate of 67%, and a CDR of 68.9%.

## Historical CDR Data

The following graph depicts the CDR from previous quarters to current:




## Primary Reasons for Denial

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.

***Medical Documentation***

- 53% of the denied claims did not meet one or more of the three coverage criteria:
  1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, or.
  2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
  3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
- 10% of the denied claims did not include medical documentation.

***Written Order Prior to Delivery***

- 16% of the denied claims contained a written order prior to delivery that was missing an order date/start date.
- 14% of the denied claims contained a written order prior to delivery that did not include a narrative description or a brand name/model number of the item being dispensed.
- 10% of the denied claims contained a written order prior to delivery that was dated after delivery.
- 8% of the denied claims were missing a written order prior to delivery.

***Proof of Delivery Issues***

- 14% of the denied claims contained proof of delivery that had a delivery date that was different than the date of service.
- 6% of the denied claims were missing a proof of delivery.

***Claim History Issues***

- 9% of the denied claims had a same/similar item in Medicare history records.

## 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 Group 2 Pressure Reducing Support Surface claims:

**Example 1**

Received:

- A written order prior to delivery which includes the beneficiary's name, Physician's name, date of the order and the start date, if start date is different from the date of the order, and Physician signature and signature date;
- Medical records consisting of wound care notes and visiting nurse notes.
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:

- A written order prior to delivery that included a detailed description of the item being ordered.
- Wound care notes and visiting nurse notes that contained the following information in order to determine that the beneficiary met the coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, or
    2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

**Example 2**

Received:

- A written order prior to delivery which includes the beneficiary's name, Physician's name, date of the order and the start date, if start date is different from the date of the order, detailed description of the item(s), and Physician signature and signature date;
- Medical records consisting of wound care notes, hospital records and visiting physician notes;
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:

- A written order prior to delivery that was signed by the treating physician before delivery.
- Wound clinic notes that contained the following information in order to determine that the beneficiary met the coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program,
    2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or

3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

- Proof of delivery that contained a delivery date that was the same as the date of service.

**Example 3**

Received:

- A written order prior to delivery which includes the beneficiary's name, Physician's name, detailed description of the item(s), and Physician signature and signature date;
- Medical records consisting of physician's notes;
- Proof of delivery which includes the beneficiary's name, delivery address, sufficiently detailed description to identify the item being delivered, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:

- A written order prior to delivery with an order date/start date.
- Physician's notes that contained the following information in order to determine that the beneficiary met the coverage criteria:
  1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program,
  2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
  3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
- Proof of delivery that contained a delivery date that was the same as the date of service.

## Next Step

Based on the results of this prepayment review, DME MAC A will continue with a prepay complex widespread medical review of claims for Group 2 Pressure Reducing Support Surfaces, HCPCS E0277.

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

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

## Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for Group 2 Pressure Reducing Support Surfaces claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- Pressure Reducing Support Surfaces - Group 2 (L5068)
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- Hospital Beds with Mattresses, Group I and Group II Support Mattresses
  **http://www.medicarenhic.com/viewdoc.aspx?id=190**

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

- Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces
  **http://www.medicarenhic.com/viewdoc.aspx?id=2311**

- Results of Widespread Prepayment Complex Medical Review for Group 2 Pressure Reducing Support Surfaces (Posted 02/25/2014, 05/29/2014, 09/25/2014)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

## 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 2014 through June 2014 and resulted in a 79.9% Charge Denial Rate (CDR).

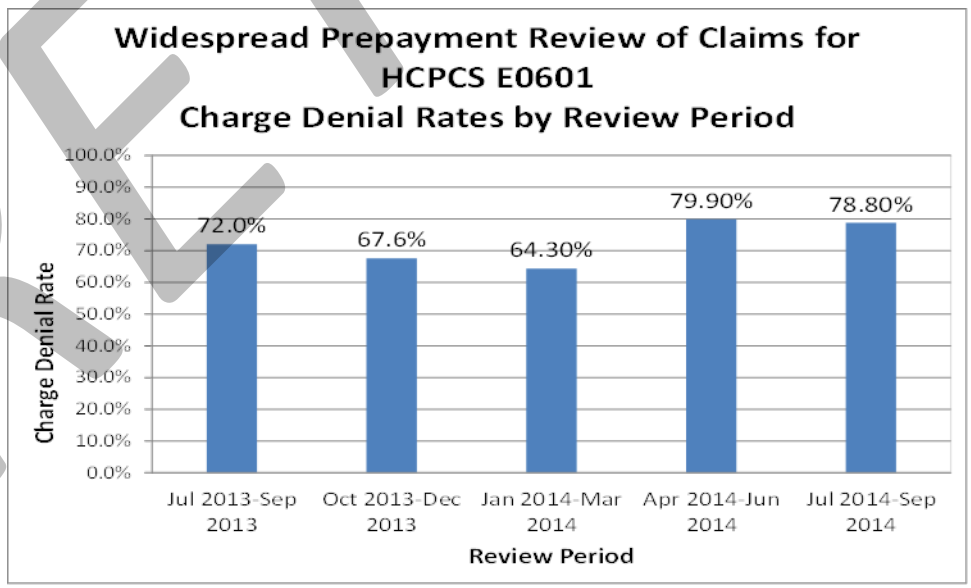
### Current Review Results

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 2014 through September 2014. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 1,847 claims submitted by 393 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 337 (18%) of the claims. Of the 1,510 claims for which responses were received, 249 claims were allowed and 1,261 were denied/partially denied. This resulted in a claim denial rate of 83.5%. 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 78.8%.

### Charge Denial Rate Historical Data

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



## Primary Reasons for Denial

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

***Face-to-Face Clinical Evaluation Documentation Issues***

- 10.8% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
    - These claims had no Face-to-Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement. Scenarios included are as follows:
        A. Beneficiaries seeking initial coverage of a PAP device
        B. Beneficiaries seeking PAP replacement following the 5 year RUL
        C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare
- 12.0% 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.
- 2.7% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 3.7% of the denied claims had Face-to-Face clinical evaluations which were untimely. Timely documentation is defined as a record in the preceding 12 months as per the PAP LCD.

***Detailed Written Order/Written Order Prior to Delivery Issues***

- 0.6% of the denied claims did not include the Detailed Written Order.
- 63.5% of the denied claims had an incomplete Written Order Prior to Delivery (for claims with a Date of Service on or after January 1, 2014) Included in these for incomplete Written Order Prior to Delivery were orders which were missing either:
    A. Beneficiary's name
    B. Detailed description of the item(s) ordered
    C. The prescribing practitioner's National Provider Identification (NPI)
    D. The signature and signature date of the prescribing practitioner
    E. The date of the order
    F. The Detailed Written Order was signed on or before Delivery, or
    G. A date of receipt demonstrating supplier receipt of Detailed Written Order on or before the Delivery
- 26.2 % of the claims had an incomplete Detailed Written Order. Included in these for incomplete Detailed Written Order were orders which were missing either:
    A. Beneficiary's name
    B. Physician's name
    C. Date of the order and the start date, if start date is different from start of order
    D. Detailed description of item(s) ordered
    E. Physician signature and signature date

  Also included in this calculation are orders which contain incompatible combination of items.

***Sleep Study Documentation Issues***

- 3.4% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 2.7% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 5.9% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

- 2.1% of the denied claims had Sleep Study documents that were missing a practitioner's interpretation of the Sleep Study findings per the PAP LCD.
- 1.3% of the denied claims had Sleep Study documents which were untimely. Timely documentation is defined as a record in the preceding 12 months as per the PAP LCD.

***Training Documentation Issues***

- 7.9% of the denied claims did not include evidence of training on the PAP device.
- 6.6% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.

## Delivery Issues

- 2.1% of the denied claims were missing Proof of Delivery.
- 6.5% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature.
- 0.7% of the denied claims were delivered after the Date of Service.
- 1.5% of the denied claims since Date of Service did not match delivery date.

## 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 PAP claims:

**Example 1**

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The Written Order Prior to Delivery is missing a date stamp clearly showing supplier receipt prior to delivery of the E0601 PAP device. The Written Order Prior to Delivery contains alterations which do not comply with accepted record keeping principles.

**Example 2**

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The submitted documentation did not include a Medicare approved sleep study. The Face-to-Face clinical evaluation had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. The Proof of Delivery was missing the beneficiary's delivery address.

**Example 3**

Received: Included in this claim is a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, a Medicare approved Sleep Study, Proof of Delivery.
Missing: The Detailed Written Order/Written Order Prior to Delivery is invalid as it contains incompatible combinations of items and is missing the ordering clinician's printed name. The claim is also missing evidence of Training on the PAP device.

## 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.

DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews.

One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs).

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

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

## Educational References

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

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

- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601) (Posted 09/18/2014, 05/29/2014, 02/27/2014, 11/22/2013, 08/30/2013, 05/31/2013, 02/28/2013, 11/30/2012, 08/24/2012, 04/20/2012, 12/22/2011, 08/19/2011, 03/04/2011 and 07/02/2010)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

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

- ACA Requirement for Indicating Receipt Date of Documentation
  **http://www.medicarenhic.com/viewdoc.aspx?id=2839**

- CERT Documentation Checklist
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- CERT Error Articles (Quarterly Publications)
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- Frequently Asked Questions (search words PAP, CPAP, E0601)
  **http://www.medicarenhic.com/faqs.aspx?categories=DME**

# Results of Widespread Prepayment Review of Claims for HCPCS 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 January 2014 through March 2014 and resulted in a 64.3% Charge Denial Rate (CDR).

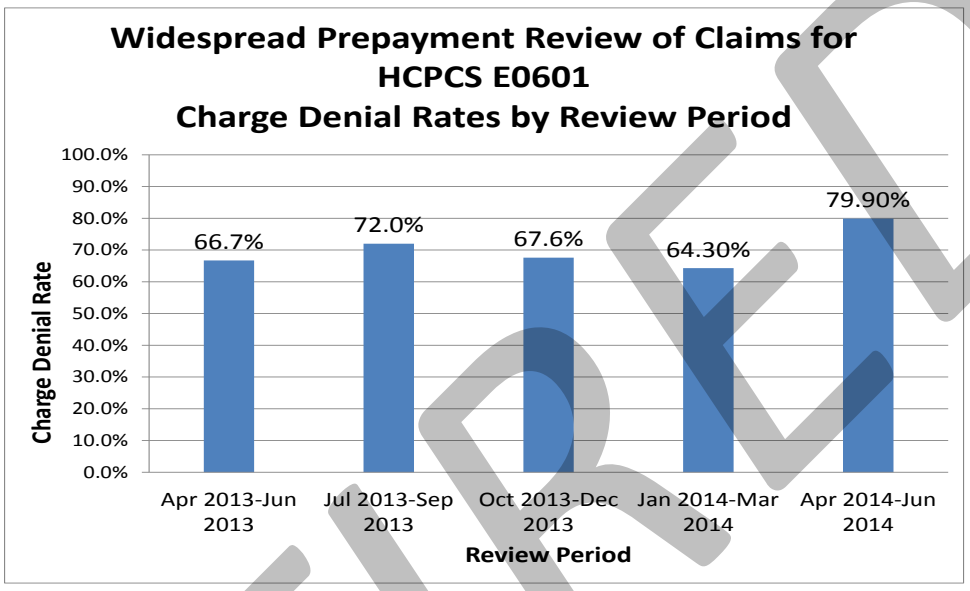
## Current Review Results

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 April 2014 through June 2014. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 1,490 claims submitted by 373 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 284 (19%) of the claims. Of the 1,195 claims for which responses were received, 200 claims were allowed and 995 were denied/partially denied. This resulted in a claim denial rate of 83.2%. 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 79.9%.

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

***Face-to-Face Clinical Evaluation Documentation Issues***

- 14.4% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
  - These claims had no Face-to-Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement. Scenarios included are as follows:
    A. Beneficiaries seeking initial coverage of a PAP device
    B. Beneficiaries seeking PAP replacement following the 5 year RUL
    C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare
- 14.7% 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.
- 2.3% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 0.7% of the denied claims had illegible Face-to-Face documents.

***Detailed Written Order/Written Order Prior to Delivery Issues***

- 2.7% of the denied claims did not include the Detailed Written Order.
- 57.3% of the denied claims had an incomplete Written Order Prior to Delivery (for claims with a Date of Service on or after January 1, 2014) Included in these for incomplete Written Order Prior to Delivery were orders which were missing either:
    A. Beneficiary's name
    B. The E0601 PAP device ordered
    C. The prescribing practitioner's National Provider Identification (NPI)
    D. The signature of the prescribing practitioner
    E. The date of the order
    F. The Detailed Written Order was signed on or before Delivery, or
    G. A date of receipt demonstrating supplier receipt of Detailed Written Order on or before the Delivery
- 27.0 % of the claims had an incomplete Detailed Written Order. Included in these for incomplete Detailed Written Order were orders which were missing either:
    A. Beneficiary's name
    B. Physician's name
    C. Date of the order and the start date, if start date is different from start of order
    D. Detailed description of item(s) ordered
    E. Physician signature and signature date

  Also included in this calculation are orders which contain incompatible combination of items.
- 1.0% of the denied claims had a Detailed Written Order which was illegible.

***Sleep Study Documentation Issues***

- 4.7% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 4.8% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 6.5% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

***Training Documentation Issues***

- 11.9% of the denied claims did not include evidence of training on the PAP device.
- 4.7% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.
- Delivery Issues
- 3.4% of the denied claims were missing Proof of Delivery.
- 7.7% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature.
- 0.8% of the denied claims were delivered after the Date of Service.
- 3.7% of the denied claims were delivered before the Date of Service.

## Claim Examples

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

**Example 1:**

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

Missing: The Written Order Prior to Delivery is missing a date stamp clearly showing supplier receipt prior to delivery of the E0601 PAP device. The Written Order Prior to Delivery is also missing the prescribing practitioner's National Provider Identification (NPI).

**Example 2:**

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, a Medicare approved Home Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The submitted documentation 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.

**Example 3:**

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, a Medicare approved Sleep Study, Proof of Delivery, and evidence of Training on the PAP device.
Missing: The Detailed Written Order/Written Order Prior to Delivery is invalid as it contains incompatible combinations of items.

## 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.

DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews.

One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs).

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

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

## Educational References

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

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

- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601) (Posted 05/29/2014; 02/27/2014; 11/22/2013; 08/30/2013; 05/31/2013; 02/28/2013; 11/30/2012; 08/24/2012; 04/20/2012; 12/22/2011; 08/19/2011; 03/04/2011 and 07/02/2010)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

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

- CERT Documentation Checklist
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- CERT Errors (Quarterly Publications)
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- Frequently Asked Questions (search words PAP, CPAP, E0601)
  **http://www.medicarenhic.com/faqs.aspx?categories=DME**

- PAP Webinars (Scheduled for September 16th, 2014 and October 14th, 2014)
  **http://www.medicarenhic.com/dme/rcseminars.aspx#webinars**

## 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

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. 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 is the Charge Denial Rate (CDR). The previous quarterly findings covered the period from October 1, 2013 through December 31, 2013 and resulted in a CDR of 84.1%.

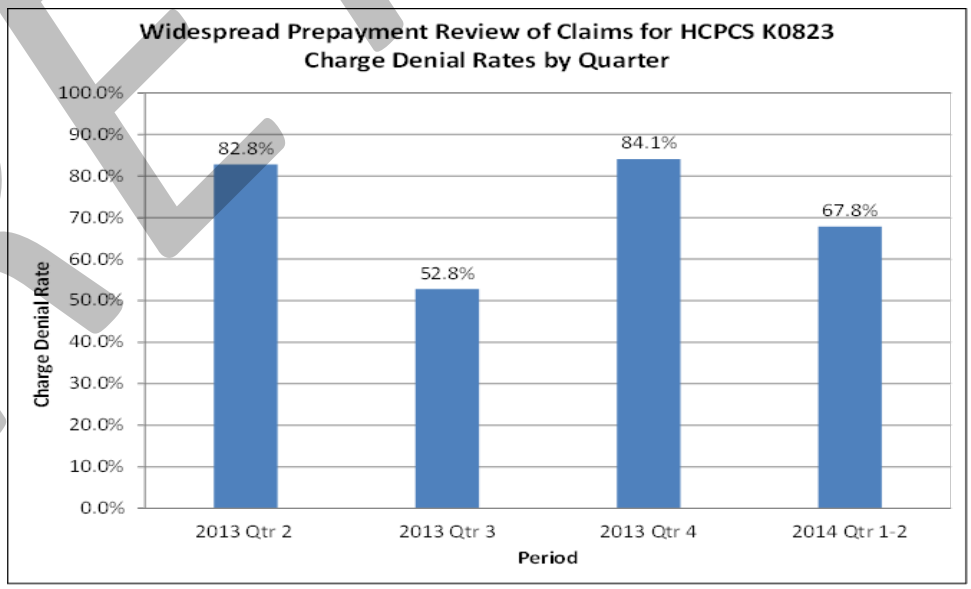
### Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings include claims with dates processed from January 1, 2014 through June 30, 2014.

This review involved prepayment complex medical review of 90 claims submitted by 40 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 28 (31%) of the ADR requests issued. Of the 62 claims for which responses were received, 12 of the claims were allowed and 50 of the claims were denied. This resulted in a claim denial rate of 80%, and a CDR of 67.8%.

### Historical CDR Data

The following graph depicts the CDR from previous quarters to current:



## Primary Reasons for Denial

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 Examination***

- 31% of the denied claims had insufficient clinical documentation to meet the General Coverage Criteria as outlined in LCD L21271 for Power Mobility Devices.
- 8% of the denied claims did not include confirmation the supplier received a copy of the Face-to-Face examination within 45 days of the completion of the Face-to-Face exam; as verified by a supplier date stamp or equivalent.
- 8% of the denied claims were missing the Face-to-Face examination.
- 4% of the denied claims included a Face-to-Face examination that was not completed by the same practitioner that signed the 7-Element Order.
- 4% of the denied claims included a Face-to-Face examination that included an addendum that did not comply with record keeping principles.

***7-Element Order***

- 10% of the denied claims did not include confirmation the supplier received a copy of the 7-Element Order within 45 days after the completion of the Face-to-Face Clinical Evaluation as verified by a supplier date stamp or equivalent.
- 10% of the denied claims contained a 7-Element Order with an invalid date of the Face-to-Face examination.
- 8% of the denied claims contained a 7-Element Order that was missing the date of the Face-to-Face examination.
- 6% of the denied claims included confirmation the supplier received a copy of the 7-Element Order, but not within 45 days of the completion of the Face-to-Face examination.
- 4% of the denied claims did not include a 7-Element Order.

***LCMP Examination***

- 6% of the denied claims contained medical documentation in which the treating physician did not state concurrence with the LCMP Examination, either in the Face-to-Face documentation or on the LCMP Examination.
- 6% of the denied claims did not include a signed and dated attestation by the supplier or licensed/certified medical professional (LCMP) stating they have no financial relationship with the supplier.

***Detailed Product Description (DPD)***

- 10% of the denied claims did not include confirmation the supplier received a copy of the DPD prior to the delivery of the power wheelchair, as verified with a date stamp or equivalent from the supplier.
- 10% of the denied claims did not include a DPD.

***Proof of Delivery***

- 15% of the denied claims were missing a Proof of Delivery.
- 8% of the denied claims contained a Proof of Delivery in which there was not a sufficiently detailed description to identify the item(s) being delivered.

***Home Assessment***

- 17% 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 Wheelchair.
- 4% of the denied claims had Home Assessments that did not demonstrate that the beneficiary can adequately maneuver the device throughout the home in terms of the actual physical layout, doorway width, doorway thresholds and surfaces.

## Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

**Example 1**

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Examination, and Proof of Delivery.

Missing: The Face-to-Face examination did not include documentation that demonstrated the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) within their home and did not specify objective measurements of the beneficiary's limitations for performing mobility related activities of daily living. The Face-to-Face examination also does not indicate that the use of a power operated vehicle (POV) has been excluded. The Face-to-Face Examination and 7-Element Order did not include confirmation that the supplier received a copy of these documents within 45 days of the completion of the Face-to-Face Evaluation as verified with a date stamp or equivalent from the supplier. The Detailed Product Description and Home Assessment were missing from this submission.

**Example 2**

Received: Documentation provided in this claim included: the 7-Element Order, Detailed Product Description, Home Assessment and Proof of Delivery.

Missing: The documentation submitted for review does not include a Face-to-Face examination. The 7-Element Order contains an invalid date of the Face-to-Face examination and the detailed product description contains insufficient detail to properly identify the item(s) to be dispensed in order to determine they are properly coded.

**Example 3**

Received: Documentation provided in this claim included: Face-to-Face Examination, 7-Element Order and Detailed Product Description.

Missing: The Face-to-Face examination did not include documentation that demonstrated the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) within their home and did not specify objective measurements of the beneficiary's limitations for performing mobility related activities of daily living. The Face-to-Face examination also does not indicate that the use of a power operated vehicle (POV) has been excluded. The 7-Element Order does not contain a date of the Face-to-Face examination or a length of need. The Detailed Product Description did not include confirmation the supplier received a copy of the DPD prior to the delivery of the power wheelchair, as verified with a date stamp or equivalent from the supplier. The documentation submitted for review does not include Proof of Delivery or a Home Assessment.

## Next Step

Billing Patterns and Documentation Compliance Reviews (DCR) will continue to be monitored by NHIC for further complex prepay review.

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

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

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

## Educational References

NHIC Corp. DME MAC and CMS provide extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- Power Mobility Devices (L21271) LCD
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios (Posted 04/05/2013)
  **http://www.medicarenhic.com/viewdoc.aspx?id=1591**

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

- Results of Widespread Prepayment Review for Group 2 Pressure Reducing Support Surfaces (HCPCs Code E0277) (Posted 12/17/2013, 06/28/2013, 03/28/2013, 12/20/2012, 09/28/2012, 07/13/2012, 04/20/2012, 12/15/2011, 08/26/2011, 06/10/2011, 03/11/2011 and 11/05/2010)
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network, ICN 905063)
  **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf**

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## Results of Widespread Prepayment Review of Claims for L0631/L0637, Lumbar-Sacral Orthoses (L11470) (O&P)

### Historical Review Results

DME MAC A Medical Review continues to review Lumbar-Sacral Orthoses (L0631 and L0637) based upon results of initial findings. The initial findings covered a period from January 13, 2014 - April 13, 2014 and resulted in a Charge Denial Rate of 83.3%.

### Current Review Results

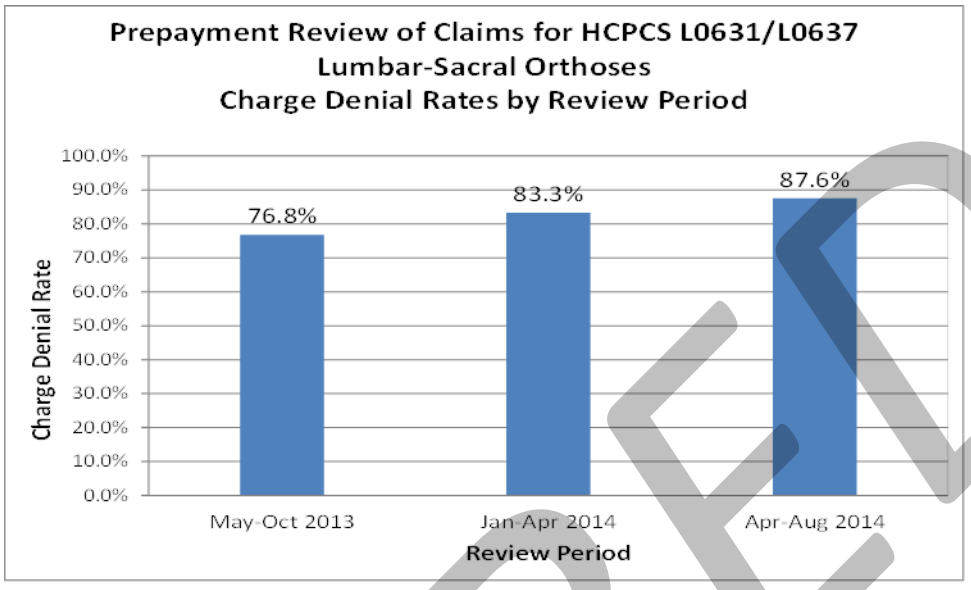
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Lumbar-Sacral Orthoses. This probe initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

- HCPCS code L0631 is a Lumbar-Sacral Orthoses, sagittal control with rigid anterior and posterior panels, posterior extends from sacroccoccygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment.
- HCPCS code L0637 is a Lumbar-Sacral Orthoses, sagittal-cornal control with rigid anterior and posterior fram/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment. This probe was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 2,166 claims submitted by 361 suppliers. These claims were reviewed from **April 15, 2014 - August 28, 2014**. Responses to the Additional Documentation Request (ADR) were not received for 887 (41%) of the claims. For the remaining 1,279 claims, 214 claims were allowed and 1,065 were denied resulting in a claim denial rate of 83%. 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 87.6%.

## Charge Denial Rate Historical Data

The following graph depicts the Charge Denial Rate from previous review periods 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. Also note that claims can be denied for multiple reasons therefore the percentages of reviews may not add up to 100%:

### *Detailed Written Orders Issues*

- Denied claims were missing a Detailed Written Order (DWO) (25%)
- Denied claims included an incomplete order (5%)
    - DWOs submitted were not legible (2%)
    - DWOs missing start date and/or signature date (2%)
    - DWOs did not list a beneficiary name (1%)

### *Medical Record Documentation Issues*

- Denied claims missing the clinical documentation to support medical necessity (19%)
- Denied claims upon review of clinical documentation (20%)
    - Clinician notes submitted show a different beneficiary than stated within the claim submitted (1%)
    - Clinician notes submitted did not support medical necessity. The documentation submitted did not demonstrate the treatment of an illness or injury to improve functioning of the spine or trunk on the body (16%)
    - Medical documentation was not authenticated by the clinician conducting the exam (3%)

### *Proof of Delivery Issues*

- Denied claims were missing the proof of delivery (15%)
- Proof of Delivery included delivery tickets not having required elements (13%)
    - Delivery ticket did not include signature of beneficiary or Beneficiary's representative; unable to determine beneficiary received items billed (3%)
    - Delivery ticket dates do not match shipping/receiving dates for items as defined within the LCD L11470 (14%)

## 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 Lumbar-Sacral Orthoses 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 clinician'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 item(s) billed. Proof of Delivery, with all the required elements was submitted.
Missing: Clinical documentation to support medical necessity of item which includes the name of beneficiary, date of appointment (before date of service), and clinician's signature.

**Example 2:**

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items dispensed, treating clinician's signature and date, and the start date of order.
Missing: Clinical documentation to support medical necessity of item includes the name of beneficiary, date of appointment (before date of service), and clinician's signature. The submitted clinical documentation did not support the medical necessity. Proof of delivery, with all of the required elements was not submitted.

**Example 3:**

Received: The supplier submitted clinical documentation to support medical necessity of item which includes the name of beneficiary, date of appointment (before date of service), and clinician's signature. Proof of delivery, with all of the required elements was submitted.
Missing: A detailed written order, which includes the beneficiary's name, specific items dispensed, treating clinician's signature and start date of order.

## Next Step

Based upon the results of initial prepayment review, DME MAC A will continue to review claims for Lumbar- Sacral Orthoses, HCPCS codes L0631/L0637.

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

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

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 Lumbar-Sacral Orthoses 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 Spinal Orthoses: TLSO and LSO (L11470)
  **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

- The *DME MAC Jurisdiction A Supplier Manual* - Chapter 10 - additional information regarding general coverage and documentation requirements
  **http://www.medicarenhic.com/dme/supmandownload.aspx**

- Results of Prepay Probe for Lumbar-Sacral Orthoses
  **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

# 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 January 1, 2014 through March 31, 2014 and resulted in a 44 % Charge Denial Rate (CDR).

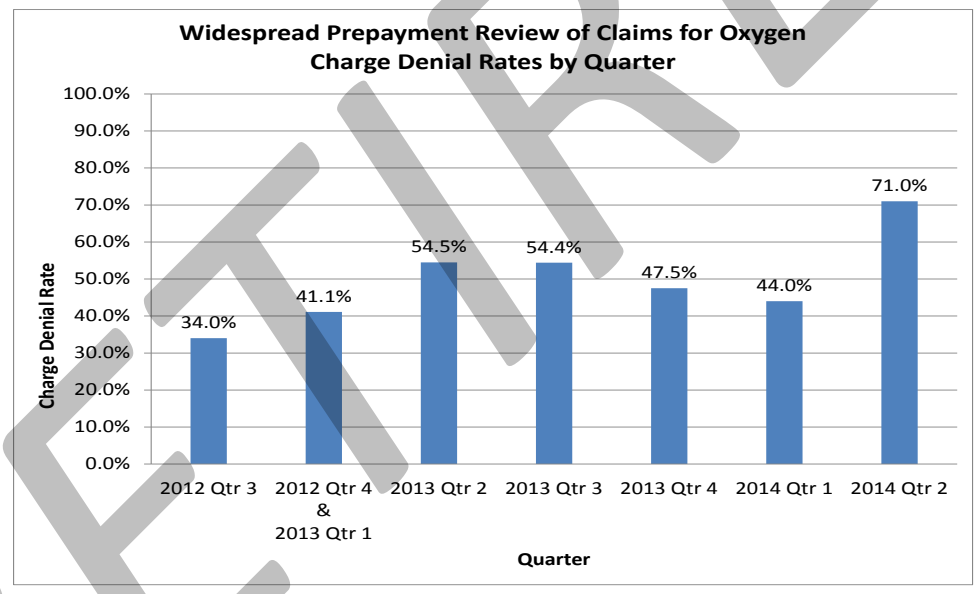
## Current Review Results

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 April 1, 2014 through June 30, 2014.

The review involved prepayment complex medical review of 698 claims submitted by 148 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 119 (17%) of the claims. For the remaining 579 claims, 197 claims were allowed and 382 were denied resulting in a claim denial rate of 66%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 71%.

## Charge Denial Rate Historical Data

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




The Coverage Indications, Limitations 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.

***Written Order Prior to Delivery Requirements Not Met (35%)***

*Documentation did not meet the written order prior to delivery requirements for items E0431 and E0439 outlined in LCD L11468 for dates of service on or after January 1, 2014 for the following reasons:*

- Detailed written order did not include the receipt date (81%)
- Detailed written order was missing the prescribing practitioner's NPI (39%)
- Detailed written order was missing a description of the DME items ordered (36%)
- Detailed written order was signed after the date of delivery (22%)
- Date stamp/fax date was dated after the date of delivery (3%)
- Detailed written order was missing the start date/signature date (1%)
- No written order prior to delivery submitted (<1%)

***Missing Documentation (34%)***

*Missing required physician visit per Local Coverage Determination (LCD) L11468:*

- 21% - Missing treating physician visit within 30 days prior to the date of the Initial Certification

*Missing qualifying blood gas study per LCD L11468:*

- 7% - No documentation to validate oxygen testing

*Missing required Certificate of Medical Necessity per LCD L11468:*

- 4% - Missing an Initial CMN or Initial CMN was incomplete

*Missing valid proof of delivery per LCD L11468:*

- 2% - Missing valid proof of delivery

***Clinical Documentation Issues: Medical Necessity could not be established (31%)***

*Clinical documentation did not support criteria of LCD L11468 for the following reasons (26%):*

- Medical documentation does not demonstrate that beneficiary was tested in a chronic stable state (9%)
- Signature requirements were not met (9%)
- No indication in medical documentation of presence of severe lung disease or hypoxia related symptoms (4%)
- Documentation submitted was illegible (1%)
- Replacement oxygen requirements not met (1%)
- Documentation did not demonstrate that alternative treatment measures had been tried and ruled out (1%)
- Documentation submitted was for an incorrect beneficiary (1%)
- No documentation submitted (<1%)
- Accepted record keeping principles were not followed (<1%)

*Clinical documentation did not support criteria indicated on CMN for the following reasons (5%)*

- Documentation of a blood gas study performed during exercise did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy (4%)
- Documentation of a blood gas study performed during sleep did not demonstrate that the beneficiary's saturation was at or below 88% for at least 5 minutes (<1%)
- Missing documentation of a polysomnogram for a beneficiary with obstructive sleep apnea (<1%)
- Medical documentation did not support that beneficiary was tested within 2 days prior to discharge, as indicated on the CMN submitted (<1%)

## 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 4/24/14**
**Code(s) Billed: E1390, E0431**

Documentation Received: Written order prior to delivery signed and dated 4/24/14; initial CMN dated 4/24/14; face sheet; physician's progress note dated 4/24/14 that includes a qualifying diagnosis; medical note dated 4/24/14 that supports the blood gas study results on the CMN; proof of delivery dated 4/24/14
Missing: Prescribing practitioner's NPI on the written order prior to delivery; legible signature on the physician's progress notes or a signature log

**Example 2:**
**DOS 5/2/14**
**Code(s) Billed: E1390**

Documentation Received: Dispensing order signed and dated 4/30/14; physical therapy notes dated 4/30/14 that include the results of exercise oximetry testing; proof of delivery dated 5/2/14; initial CMN dated 5/2/14; face sheet; privacy notice; supplier forms
Missing: Documentation of a physician visit dated within 30 days prior to the initial date of service documenting the qualifying diagnosis, documentation of exercise oximetry testing in the medical record that meets the LCD testing criteria

**Example 3:**
**DOS 1/23/14-2/23/14**
**Code(s) Billed: E1390, E0431**

Documentation Received: Progress note dated 1/23/14; written order prior to delivery signed and dated 1/23/14; initial CMN dated 1/23/14; proof of delivery; supplier forms
Missing: A date stamp or similar on the written order prior to delivery demonstrating supplier receipt prior to delivery of item; documentation of a physician visit dated within 30 days prior to the initial date of service documenting the qualifying diagnosis; documentation of oximetry testing in the medical record that supports the blood gas study results on the CMN

## 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.

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

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

## Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to review the following references:

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

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

- CERT Error Articles - Monthly publications
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- Physician Letter - Home Oxygen Initial Qualification Testing
  **http://www.medicarenhic.com/dme/mobile/index.html**

- Physician Letter - Face-to-Face and Written Order Requirements for High Cost DME
  **http://www.medicarenhic.com/dme/mobile/index.html**

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

- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: May 29. 2014; February 25, 2014; November 27, 2013; August 30, 2013; May 17, 2013; February 8, 2013; 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/mrbulletinpca.aspx**

- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  **http://www.medicarenhic.com/viewdoc.aspx?id=2692**

## 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. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. 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 result is the Charge Denial Rate (CDR).The previous quarterly findings covered the period of April 1, 2014 through June 30, 2014 and resulted in a CDR of 71%.

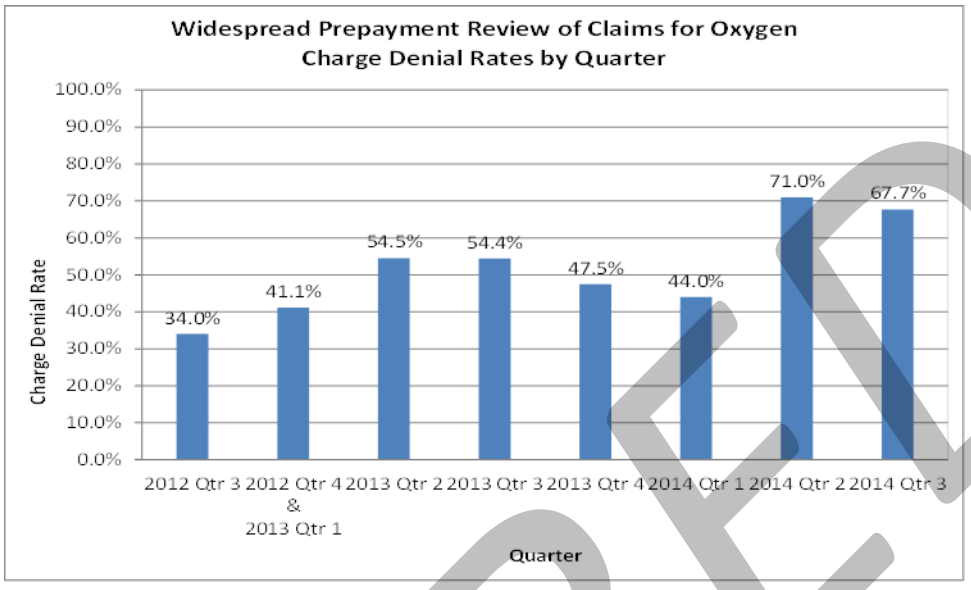
### Current Review Results

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, 2014 through September 30, 2014.

The review involved prepayment complex medical review of 453 claims submitted by 113 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 9 (2%) of the claims. For the remaining 444 claims, 198 claims were allowed and 246 were denied resulting in a claim denial rate of 55%, and a CDR of 67.7%.

## Charge Denial Rate Historical Data

The following graph depicts the CDR from previous quarters to current:




The Coverage Indications, Limitations 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 beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated 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 beneficiary is in a chronic stable state - i.e. not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11468 and related Policy article for additional information.

## Primary Reasons for Denial

The following are the primary reasons for denial.

***Written Order Prior to Delivery Requirements Not Met (58%)***

*Documentation did not meet the written order prior to delivery requirements for items E0431 and E0439 outlined in LCD L11468 for dates of service on or after January 1, 2014 for the following reasons:*

- No evidence, by date stamp or similar, that the supplier received the detailed written order prior to delivery (86%)
- Detailed written order was missing a description of the DME item(s) ordered (25%)
- Detailed written order was missing the prescribing practitioner's NPI (14%)
- Detailed written order was signed after the date of delivery (3%)
- Detailed written order was received after the date of delivery (1%)
- Detailed written order was missing the signature date (1%)
- No detailed written order submitted (1%)
- Detailed written order was illegible (1%)
- Detailed written order missing the prescribing practitioner's signature (<1%)

***Missing Documentation (22%)***

*Missing required physician visit per Local Coverage Determination (LCD) L11468:*

- 9% - Missing treating physician visit within 30 days prior to the date of the Initial Certification

*Missing qualifying blood gas study per LCD L11468:*

- 6% - No medical documentation to support the blood gas study reported on the CMN

*Missing required Certificate of Medical Necessity per LCD L11468:*

- 6% - Missing an Initial CMN or Initial CMN was invalid

*Missing valid proof of delivery per LCD L11468:*

- 1% - Missing valid proof of delivery

***Clinical Documentation Issues: Medical Necessity could not be established (20%)***

*Clinical documentation did not support criteria of LCD L11468 for the following reasons:*

- Medical documentation did not demonstrate that beneficiary was tested in a chronic stable state (6%)
- Signature requirements were not met (4%)
- Documentation of a blood gas study performed during exercise did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy (4%)
- No indication in medical documentation of presence of severe lung disease or hypoxia related symptoms (3%)
- Missing documentation of a polysomnogram for a beneficiary with obstructive sleep apnea (1%)
- Replacement oxygen requirements not met - missing the RA modifier and a narrative explanation of why the equipment was replaced (1%)
- Accepted record keeping principles were not followed - corrections made to a document without the author initialing and dating the correction (1%)

## 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 5/2/14**
**Code(s) Billed: E1390, E0431**

Documentation received: Written order prior to delivery signed and dated 5/2/14; initial CMN dated 5/2/14; hospital admission note dated 4/27/14; discharge summary note dated 5/2/14; proof of delivery dated 5/2/14
Missing: Proof of receipt on the written order prior to delivery; documentation of oximetry testing in the medical record to support the blood gas study results on the CMN

**Example 2:**
**DOS 3/26/14**
**Code(s) Billed: E1390, E0431**

Documentation received: Written order prior to delivery signed 3/24/14 that meets the *Affordable Care Act* requirements; pulse oximetry flow sheet; initial CMN dated 3/26/14; physician progress note dated 1/15/14; proof of delivery dated 3/26/14
Missing: Documentation of a physician visit dated within 30 days prior to the initial date of service documenting the qualifying diagnosis; documentation of oximetry testing in the medical record to support the blood gas study results on the CMN

**Example 3:**
**DOS 4/25/14**
**Code(s) Billed: E1390, E0431**

Documentation received: Written order prior to delivery signed and dated 4/16/14; initial CMN dated 4/25/14; progress note dated 4/14/14; proof of delivery dated 4/15/14; supplier forms
Missing: A detailed description of the item ordered on the written order prior to delivery; a legible signature or printed name on the progress note or a signature log

## 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.

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

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

## Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

Suppliers are encouraged to review the following references:

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

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

- CERT Error articles
  **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

- CERT Physician Letter - Home Oxygen Initial Qualification Testing
  **http://www.medicarenhic.com/dme/mobile/index.html**

- CERT Physician Letter - Face-to-Face and Written Order Requirements for High Cost DME
  **http://www.medicarenhic.com/dme/mobile/index.html**

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

- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: September 18, 2014; May 29. 2014; February 25, 2014; November 27, 2013; August 30, 2013; May 17, 2013; February 8, 2013; 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/mrbulletinpca.aspx**

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

# Standard Documentation Language for Local Coverage Determinations and Related Policy Articles - Revised - Joint DME MAC Publication (GEN)

**Note:** *This is a revision to a previously article published in October 2014 entitled, "Standard Documentation Language for Local Coverage Determinations and related Policy Articles - Revised". This version adds information on repairs in the Policy Specific Documentation Section of the LCDs.*

Many errors reported in DME MAC MR Reviews and CERT Audits arise from problems associated with submitted documentation; consequently, the DME MACs have created a standardized language for use in Local Coverage Determinations and related Policy Articles. Standardized language first appeared in 2012 and with subsequent changes in CMS and DME MAC program instructions, is being revised with this publication. The updated language will be inserted in the applicable LCDs and related PAs upcoming revisions to these policies.

The standard sections are written in a modular format to allow each policy to contain information relevant to that policy while not including material that does not apply. This article provides a complete listing of all of the documentation requirement modules. All modules may not be used in every LCD. For example, the CMN sections would not be included in the DOCUMENTATION REQUIREMENTS section of an LCD for an item that does not require a CMN.

*****IMPORTANT*****

Many policies contain coverage and documentation requirements that are unique to that specific policy. Such unique information is not included in this article. It is important that suppliers review the actual LCD to be sure to have all of the relevant information necessary applicable to the item(s) provided.

In several places you will see "placeholders" like "XXX" or "###". Information specific to the policy will be inserted in these spots. Occasionally you may also see "Editor Note" comments. These notes are used to indicate where optional sections may be inserted, when applicable and formatting information.

## Standard Language

***LCD***

*COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY*

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on *Social Security Act* §1862(a)(1)(A) provisions, are defined by the following indications and limitations of coverage and/or medical necessity.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee for Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

*DWO Verbiage*

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

*ACA WOPD*

(**Editor Note:** *Insert after DWO section*)

For some items in this policy to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to THE NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

**REFILL REQUIREMENTS**

(**Editor Note:** *Use for those LCDs with continuous supplies. Remember to add matching refill documentation language (see below)*)

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

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

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

**DOCUMENTATION REQUIREMENTS**

Section 1833(e) of the *Social Security Act* precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

**PRESCRIPTION (ORDER) REQUIREMENTS**

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

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

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

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

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

The dispensing order must be available upon request.

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

*ACA 6407 (Prescription Requirements, prior to DWO)*

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes specified in the table contained in the Policy Specific Documentation Requirements Section below. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. Refer the related Policy Article

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

DETAILED WRITTEN ORDERS (PIM 5.2.3)
A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

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

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

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

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

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

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

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

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.2.3)

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)
(**Editor Note:** *Only for WOPD items*)
A detailed written order prior to delivery (WOPD) is required for XXX. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

**MEDICAL RECORD INFORMATION**
GENERAL (PIM 5.7 -5.9)
The **Coverage Indications, Limitations and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Non-Medical Necessity Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or

healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED MEDICAL NEED
For all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

CONTINUED USE
Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies.
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements This is deemed to be sufficient to document continued use for the base item, as well.
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

REFILL DOCUMENTATION (PIM 5.2.5-6)
(**Editor Note:** *Only for policies with items subject to refill requirements*)
A routine refill prescription is not needed. A new prescription is needed when:

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

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

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

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request

- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) - The Supplier should assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies) - The supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

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

PROOF OF DELIVERY (PIM 4.26, 5.8)
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

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

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

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

(**Editor Note:** *Some LCDs only have 2 methods of delivery - Delete #3*)

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

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

<u>Method 1 - Direct Delivery to the Beneficiary by the Supplier</u>
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

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

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee or the supplier. When the supplier's delivery documents have both a supplier-entered date and a beneficiary or beneficiary's designee signature date on the POD document, the beneficiary or beneficiary's designee-entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2 - Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

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

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

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

Method 3 - Delivery to Nursing Facility on Behalf of a Beneficiary
When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

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

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

Equipment Retained From a Prior Payer
When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary's medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare, the suppler:

1. Must obtain a new POD as described above under "Methods of Delivery" (whichever method is applicable); or,
2. Must obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), attesting that the supplier has examined the DMEPOS item, it is in good working order and that it meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

**POLICY SPECIFIC DOCUMENTATION REQUIREMENTS**

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

{Insert code table}

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required. Refer to the related Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

GENERAL

CERTIFICATE OF MEDICAL NECESSITY (PIM 5.3)
(**Editor Note:** *Only for items requiring CMN*)
A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the physician can enter the other details directly.

(**Editor Note:** *Add specific DIF instructions as needed*)

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

DME INFORMATION FORM (PIM 5.3)
(**Editor Note:** *Only for items requiring a DIF*)
A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(**Editor Note:** *Add specific DIF instructions as needed*)

REPAIR/REPLACEMENT (BPM Ch 15, §110.2)
(Editor Note: Applies to all DMEPOS except artificial limbs)

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and,
2. Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

REPAIR/REPLACEMENT (BPM Ch 15, §120)
(**Editor Note:** *Only applies to Lower Limb Prostheses LCD*)

Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

Medicare payment may be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary. Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must be supported by a new physician's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating physician, either on the order or in the medical record, and must fall under one of the following:

1. A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,
2. An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request. It is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive beneficiary weight or prosthetic demands of very active amputees.

**MISCELLANEOUS**
Refer to the Supplier Manual for additional information on documentation requirements.

**APPENDICIES**
PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-8

For the revision history of the LCD

DOCUMENTATION REQUIREMENTS:
(**Editor 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: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

***POLICY ARTICLE***
**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**
For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on *Social Security Act* §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

DME (**Editor Note:** *Include specific name of DME item*) covered under the Durable Medical Equipment benefit (*Social Security Act* §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

Or

Prosthetic (**Editor Note:** *Include specific name of prosthetic item*) covered under the Prosthetic Devices benefit (*Social Security Act* §1861(s)(8)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

WRITTEN ORDER PRIOR TO DELIVERY
(**Editor Note:** *Only when WOPD required*)

When the supplier is required to have a written order prior to delivery but bills an item without a detailed written order, the item will be denied as statutorily excluded.

Or for Drugs

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as non-covered.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

{Select codes from table below}

Face-to-Face Visit Requirements:

As a condition for payment, Section 6407 of the *Affordable Care Act* (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the WOPD.
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals.
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier

The first bullet, "For all claims for purchases or initial rentals", includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

Prescription Requirements:

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the DMEPOS supplier's possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary's name,
- Physician's Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI),
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use

- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:

- Verify that the in-person visit occurred within the 6-months prior to the date of their prescription, and
- Have documentation of the face-to-face examination that was conducted, and
- Provide the DMEPOS supplier with copies of the in-person visit records.

Date and Timing Requirements

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Claim Denial

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily noncovered - failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

**CODING GUIDELINES**

(**Editor Note:** *Only use first paragraph when items require PDAC review*)

The only products which may be billed using codes XXX are those for which a written Coding Verification Review has been made by the Pricing, Data Analysis and Coding (PDAC) Contractor and subsequently published on the appropriate Product Classification List.

Suppliers should contact the PDAC Contractor for guidance on the correct coding of these items.

## Overpayment Refund Form Submission & Status - Now Available on our Provider Services Portal (PSP) (GEN)

NHIC DME MAC Jurisdiction A is pleased to announce that our PSP now has the capability for the submission and status of the NHIC Overpayment Refund form. While reviewing claim status details, the new option allows you to create your form and submit via the PSP. The PSP also allows for the submission of additional documentation to support your request. This option will decrease time and costs associated with submitting overpayment refund requests via fax or mail.

Don't miss out! If you are not yet signed up for our PSP you are missing a great opportunity to:

- Easily access patient eligibility and claim status
- Print a copy of a remittance
- Check for same/similar equipment history including A, L and V codes
- Submit and obtain status for Reopenings and Redeterminations
- And now submit and obtain status for the Overpayment Refund form

We encourage you to enroll in our PSP and take advantage of this opportunity to increase efficiency via the use of our free web-based portal.

Interested DME MAC A Suppliers can obtain additional information and begin the enrollment process today at the following link: **http://www.medicarenhic.com/dme/pspinvite.aspx**

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## Third Quarter 2014 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2014 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 | 87,851 | The procedure code, modifier, or procedure code and modifier combination is invalid. |
| **X222.121.2010BA.NM109.020 -** Invalid Information for a Subscriber's contract/member number | 21,627 | The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card. |
| **X222.226.2300.HI01-2.030** - Invalid Information within the Primary diagnosis code | 17,820 | The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service. |
| **X222.087.2010AA.NM109.050** - Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider | 16,690 | 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. |
| **X222.094.2010AA.REF02.050** - Billing Provider Tax Identification Number must be associated with the billing provider's NPI. | 12,890 | Verify that the information you are submitting matches the information on file with the NPPES and NSC. |
| **X222.380.2400.DTP03.080** - Invalid Information within the Future date and Date(s) of service | 9,624 | The service start/from date is greater than the date this claim was received. |

| Top Ten Claims Submission Errors | Number Received | Reason For Error |
|---|---|---|
| **X222.380.2400.DTP03.090** - Invalid Information within the Date(s) of service | 9,619 | 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. |
| **X222.351.2400.SV101-3.020** - This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered | 8,668 | Procedure Modifier must be valid for the Service Date. (DTP01 = "472"). |
| **X222.087.2010AA.NM109.030** - Invalid information in the Billing Provider's NPI | 7,843 | Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC. |
| **X222.380.2400.DTP03.070** - Invalid information within the Date(s) of service | 6,656 | The number of services entered for this line is invalid. Capped rentals can only have one unit of service. |

## Third Quarter 2014 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the third quarter of 2014. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from July through September 2014.

| 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. | 29,736 |
| **OA109, N418** This claim/service is not payable under our claims jurisdiction area. | The claim must be submitted to the correct Medicare contractor. | 12,404 |
| **CO 182, N517** Procedure modifier was invalid on the date of service | **Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed. | 10,701 |
| **CO16, N350** Claim/service lacks information which is needed for adjudication. | **Item 19** - Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code. | 4,025 |
| **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). | 2,543 |
| **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. | 1,681 |

| Claims Submission Errors (Return/Reject Denials) | CMS 1500 Form (or electronic equivalent) Entry Requirement | Number Received |
|---|---|---|
| **CO 16, N64** Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. | **Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A. | 1,349 |
| **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. | 1,195 |
| **CO 16 N257, N433** Missing / incomplete / invalid billing provider/supplier primary identifier. | **Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI). | 1,173 |
| **CO 16, MA130, M76** Missing / incomplete / invalid diagnosis or condition | **Item 21** - Claim/service lacks information with diagnosis code which is need for adjudication. | 1,169 |

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above charts and share it with your colleagues.

## DME MAC A 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**

## 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.

## Supplier Manual News (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) *Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/publications.aspx**. After accepting the CPT License Agreement, suppliers can access the entire DME MAC A *Supplier Manual*, including revised chapters and archived revisions. The *Supplier Manual* is available to current suppliers via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

**Updates/Corrections Made:**

In September of 2014 chapters 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.

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## 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.

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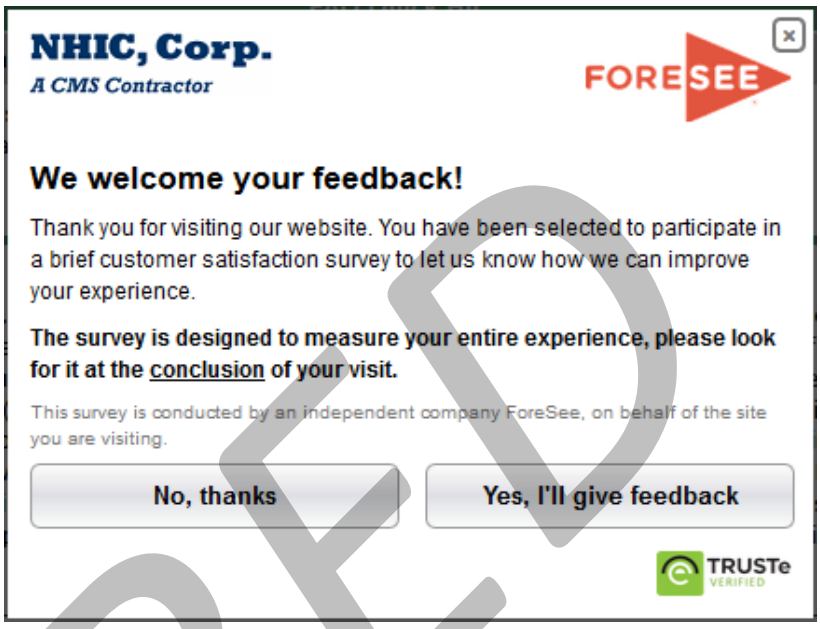
## DME MAC Jurisdiction A Web Site Customer Satisfaction Survey

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!*

## For Your Notes

# Helpful Contacts

## Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

## Outreach & Education

outreach-education@hp.com

## Claims Submissions

DME Jurisdiction A Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

## Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
**Written Inquiry FAX:** 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

## Overpayments

**Refund Checks:**
NHIC, Corp.
P.O. Box 809252
Chicago, IL 60680-9252

**Payment Offset Fax Requests:** 781-741-3916

**Note:** *Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

## Appeals and Reopenings

**Telephone Reopenings:** 317-595-4371

**Redetermination Requests Fax:** 781-741-3118

**Redetermination Request Resulting from an Overpayment**

781-383-4531

**Redeterminations:**
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

**Reconsiderations:**
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

**Faxed Reopenings:** 781-741-3914

**Redetermination For Overnight Mailings:**
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

**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:**
Wilfred Mamuya, MD PhD
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

December 2014
Number 34

## 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.: **http://www.medicarenhic.com/dme**

TriCenturion: **http://www.tricenturion.com**

CMS: **http://www.cms.gov**

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

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

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



**NHIC, Corp.**
***A CMS Contractor***

75 Sgt. William B. Terry Drive
Hingham, MA 02043