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

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Additional States Requiring Payment Edits for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics. Update to CR3959 and CR8390 (MM8730) (O&P)

MLN Matters® Number: MM8730
Related CR Release Date: May 16, 2014
Related CR Transmittal #: R1385OTN
Related Change Request (CR) #: CR 8730
Effective Date: March 3, 2014
Implementation: June 17, 2014

Provider Types Affected

This MLN Matters® Article is intended for DMEPOS suppliers in Alabama, Arkansas, Florida, Georgia, Illinois, Kentucky, Mississippi, New Jersey, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, North Dakota, Iowa, and Pennsylvania who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Prosthetics and Orthotics (P&O) provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8730 to announce the three additional states that require the use of a licensed/certified orthotist or prosthetist for furnishing of P&O. The states are North Dakota, Iowa, and Pennsylvania.

Background

CMS issued Transmittal 656, CR3959 on August 19, 2005. This CR instructed Durable Medical Equipment Regional Contractors (DMERCs, since changed to DME MACs) to implement claims processing edits to ensure compliance with CMS regulations found at 42 CFR Section 424.57(c)(1). Such regulations require DMEPOS suppliers wishing to bill Medicare to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements.

As a result of CR3959, the DME MACs implemented an edit which was programmed to deny claims for prosthetics and certain custom-fabricated orthotics when those items were furnished by personnel who were not licensed/certified as a orthotist or prosthetist by the State in which they practice. At the time CR3959 was issued and the DME MACs implemented the edit, there were nine states requiring the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. Since that time, five additional states have instituted requirements for the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. These five states are Arkansas, Georgia, Kentucky, Mississippi, and Tennessee. CR8390 instructed the DME MACs to revise the programming edits so that Arkansas, Georgia, Kentucky, Mississippi, and Tennessee are added to the logic, in accordance with CR3959.

CR8730 requires DME MACs to revise the programming edits so that North Dakota, Iowa, and Pennsylvania are added to the logic, in accordance with CRs 3959 and 8390.

In the 17 states that have indicated that provision of prosthetics and orthotics must be made by licensed/certified orthotist or prosthetist, Medicare payment may only be made for prosthetics and certain custom-fabricated orthotics when furnished by physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel. These specialties will bill for Medicare services when State law permits such entity to furnish an item of prosthetic or orthotic using the following codes:

- Medical Supply Company with Orthotics Personnel - Specialty Code 51;
- Medical Supply Company with Prosthetics Personnel - Specialty Code 52;
- Medical Supply Company with Orthotics and Prosthetics Personnel - Specialty Code 53;
- Orthotics Personnel - Specialty Code 55;

- Prosthetics Personnel - Specialty Code 56;
- Orthotics Personnel, Prosthetics Personnel, and Pedorthists - Specialty Code 57;
- Physical Therapist - Specialty Code 65;
- Occupational Therapist - Specialty Code 67;
- Pedorthic Personnel - Specialty Code B2; • Medical Supply Company with Pedorthic Personnel - Specialty Code B3;
- Ocularist - Specialty Code B5; and
- All Physician Specialty Code listed in the "*Medicare Claims Processing Manual*," Chapter 26, Section10.8.2, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf** on the CMS website.

If a supplier is located in one of the applicable states, that supplier must be properly enrolled with the National Supplier Clearinghouse (NSC) to ensure the correct specialty code(s) is on file in order to submit a claim to Medicare for the prosthetics and custom-fabricated orthotics. Failure to be properly enrolled will result in the claim being denied. A copy of the State license should be sent to the NSC if the supplier is in one of the seventeen states requiring a license.

If a supplier should need to update its' file with the correct specialty, the supplier must submit a "Change of Information" on Form CMS-855S to the NSC along with all applicable licenses or certifications. That form is available at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855s.pdf** on the CMS website. The NSC is responsible for maintaining a central data repository for information regarding suppliers. The NSC transmits this repository to the four DME MACs. The effective date for the new or revised specialty code for P&O claims will be the date the NSC issues the specialty code. The new or revised specialty code will not be applied retroactively.

Additional Information

The official instruction, CR8730 issued to your DME MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1385OTN.pdf** on the CMS website.

To review the article related to CR8390, visit **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8390.pdf** on the CMS website.

To review the CR3959, visit **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3959.pdf** on the CMS website.

If you have any questions, please contact your DME 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.

Aprepitant for Chemotherapy-Induced Emesis (MM8418) (DRU)

MLN Matters® Number: MM8418 Revised
Related CR Release Date: April 15, 2014
Related CR Transmittal #: R185BP, R2931CP, and R165NCD

Related Change Request (CR) #: CR 8418
Effective Date: May 29, 2013
Implementation Date: July 7, 2014

Note: *This article was revised on April 16, 2014, to reflect the revised CR8418, issued on April 15. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing the transmittals are revised. Also, we have deleted references to expired HCPCS codes. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8418, which informs MACs that, effective for claims with dates of service on or after May 29, 2013 , the Centers for Medicare & Medicaid Services (CMS) extends coverage of the oral antiemetic three-drug regimen of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone to beneficiaries who are receiving certain anticancer chemotherapeutic agents. Make sure that your billing personnel are aware of these changes.

Background

Chemotherapy induced emesis is the occurrence of nausea and vomiting during or after anticancer treatment with chemotherapy agents. The *Social Security Act* (the Act) permits oral drugs to be paid under Part B in very limited circumstances, one of which is antiemetic therapy administered immediately before and within 48 hours after anticancer chemotherapy as described in section1861(s)(2) of the Act. These drugs must fully replace the non-self-administered drug that would otherwise be covered.

On April 4, 2005, CMS announced a National Coverage Determination (NCD) for the use of the oral three-drug regimen of aprepitant, a 5HT3 antagonist, and dexamethasone for patients who are receiving certain highly emetogenic chemotherapeutic agents.

On May 29, 2013, CMS announced an update to that NCD, to cover the use of the oral antiemetic three-drug combination of oral aprepitant (J8501), an oral 5HT3 antagonist (Q0166, Q0179, Q0180), and oral dexamethasone (J8540) for patients receiving highly and moderately emetogenic chemotherapy. As a result, effective for services on or after May 29, 2013, the following anticancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab (J9010);
- Azacitidine (J9025);
- Bendamustine (J9033);
- Carboplatin (J9045);
- Clofarabine (J9027);
- Cytarabine (J9098, J9100);
- Daunorubicin (J9150, J9151);
- Idarubicin (J9211);
- Ifosfamide (J9208);
- Irinotecan (J9206); and
- Oxaliplatin (J9263).

Please note the entire list includes the 11 new codes listed above and the 9 existing anticancer chemotherapeutic agents listed below:

- Carmustine (J9050);
- Cisplatin (J9060);
- Cyclophosphamide (J8530, J9070);
- Dacarbazine (J9130);
- Mechlorethamine (J9230);
- Streptozocin (J9320);
- Doxorubicin (J9000, Q2049);
- Epirubicin (J9178); and
- Lomustine (S0178).

CMS also permits the MACs to determine coverage for other all-oral three-drug antiemesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in combination with an oral 5HT3 antagonist and oral dexamethasone with the chemotherapeutic agents listed, or any other anticancer chemotherapeutic agents that are FDA-approved and may in the future be defined as highly or moderately emetogenic.

CMS is defining highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC). The inclusive examples are: NCCN plus ASCO, NCCN plus ESMO/MASCC, or ASCO plus ESMO/MASCC.

Until a specific code is assigned to the new drug, any new FDA-approved oral antiemesis drug (oral NK-1 antagonist or oral 5HT3 antagonist) as part of the three-drug regimen must be billed with the following not-otherwise-classified (NOC) code effective April 1, 2014, in the IOCE update:

- Q0181 - Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

This NOC code must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (ICD9/10 codes V58.11/Z51.11).

This coverage policy applies only to the oral forms of the three-drug regimen as a full replacement for their intravenous equivalents. All other indications or combinations for the use of oral aprepitant are non-covered under Medicare Part B, but may be considered under Medicare Part D.

For claims with dates of service on or after May 29, 2013, MACs will adjust claims processed before CR8418 was implemented if you bring those claims to the attention of your MAC.

Effective for claims with dates of service on or after May 29, 2013, MACS will deny lines for oral aprepitant (J8501), or NOC code Q0181 if an encounter for antineoplastic chemotherapy identified by ICD 9/10 codes V58.11/Z51.11 is not present. The denied lines will reflect the following messages on the remittance advice:

- Claim Adjustment Reason Code 96: Non-covered Charge(s)
- Remittance Advice Remarks Code (RARC) M100: We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy; and
- RARC N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at **http://www.cms.gov/mcd/search.asp**. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Additional Information

The official instruction, CR8418, was issued to your MAC via three transmittals. The first updates the "*Medicare Benefit Policy Manual*" and that is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R185BP.pdf** on the CMS website.

The second updates the "*Medicare Claims Processing Manual*" and is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2931CP.pdf** and the third updates the "*Medicare National Coverage Determinations Manual*" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165NCD.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/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/** on the CMS website.

April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8645) (GEN)

MLN Matters® Number: MM8645
Related CR Release Date: March 11, 2014
Related CR Transmittal #: R2902CP

Related Change Request (CR) #: CR 8645
Effective Date: April 1, 2014
Implementation: April 7, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Part A/B Medicare Administrative Contractors (MACs), Hospice and Home Health (HHHMACs), 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) 8645 that alerts providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing personnel 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 CR8645

Splints, Casts and Certain Intraocular Lenses (IOLs)

The following are the HCPCS codes for splints, casts, and certain IOLs added to the DMEPOS fee schedule file:
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, V2630, V2631, V2632.

As written in the MLN Matters® Article MM8523 (Change to the Reasonable Charge Update for 2014 for Splints, Casts, and Certain Intraocular Lenses) at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8523.pdf**, for dates of service on or after April 1, 2014, payment for splints, casts and IOLs inserted in a physician's office will be made using national fee schedule amounts.

For splints and casts, codes A4565 and Q4001-Q4049 are used when supplies are indicated for cast and splint purposes and:

- Payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast. Per the regulations at 42 CFR Section 414.106, national fee schedule amounts for 2014 for these items were developed using 2013 reasonable charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June 2013, which is 1.8 percent; and
- For each year subsequent to 2014, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment as described in Section 1886(b)(3)(B)(xi)(II) of the *Social Security Act*.

For intraocular lenses (codes V2630, V2631 and V2632), payment under the DMEPOS fee schedule is only made for lenses implanted in a physician's office:

- For payment of IOLs inserted in a physician's office furnished from April 1, 2014, through December 31, 2014, regulations at 42 CFR Section 414.108 require national fee schedules be established based on the Calendar Year (CY) 2012 national average allowed charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 24-month period ending with June 2013, which is 3.5 percent;
- For each year subsequent to 2014, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, adjusted by the productivity adjustment as described in Section 1886(b)(3)(B)(xi)(II) of the Act; and
- For IOL codes V2630 and V2631, national fee schedules amounts have been established using the fee schedule amounts for comparable code V2632 since there is insufficient allowed charge data for use in calculating the fee schedule amounts.

Subject to coinsurance and deductible rules, Medicare payment for these items is to be equal to the lower of the actual charge for the item or the amount determined under the applicable fee schedule payment methodology.

Payment Category Reclassification of Certain DME

Effective for dates of service on or after April 1, 2014, certain HCPCS codes for DME are reclassified from the payment category for inexpensive or other routinely purchased DME to the payment category for capped rental items, to align with the regulatory definition of routinely purchased equipment found at 42 CFR Section 414.220(a)(2).

These changes were determined through rulemaking (CMS-1526-F) and as written in the MLN Matters® Article MM8566 titled Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category, available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf** on the CMS website.

As part of the April 2014 update to the DMEPOS fee schedule, the methodology used to calculate fee schedule amounts for capped rental items has been used to establish new fee schedule amounts for the following HCPCS codes:
A4639, A7025, E0117, E0144, E0198, E0300, E0620, E0656, E0657, E0740, E0762, E0764, E0849, E0855, E0856, E0984, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1010, E1014, E1029, E1030, E1161, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E1700, E2227, E2310, E2311, E2312, E2313, E2321, E2322, E2325, E2326, E2327, E2328, E2329, E2330, E2351, E2373, E2374, E2376, E2377, E2378, E2500, E2502, E2504, E2506, E2508, E2510, K0607, K0730.

Consistent with the capped rental payment methodology, only Rental Amounts (RR) will appear on the fee schedule file for the above codes, effective April 1, 2014, and:

- The HCPCS codes transitioning to the capped rental payment category with corresponding KC, KF or KE modifiers will continue to have rental amounts associated with these modifiers on the fee schedule file;
- The capped rental fee schedule amount is calculated based on ten percent of the base year purchase price increased by the covered item update;
- This is the fee schedule amount for rental months one through three. Beginning with the fourth month, the fee schedule amount is equal to 75 percent of the fee schedule amount paid in each of the first three rental months; and
- All of the payment rules for capped rental items, including guidelines regarding continuous use and transfer of title to the beneficiary following 13 months of continuous use, apply to these codes, effective for claims with dates of service on or after April 1, 2014.

Also effective April 1, 2014, MACs will process and pay claims for capped rental wheelchair accessories on a lump sum purchase basis when used with complex rehabilitative power wheelchairs (wheelchair base codes K0835 - K0864). In this case, the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. The purchase fee schedule amount for capped rental accessories furnished in this manner is equal to the rental fee (for months one through three) multiplied by ten. If the beneficiary declines the purchase option, the supplier must furnish the accessory on a rental basis and payment will be made in accordance with the capped rental payment rules.

Specific Coding and Pricing Issues

As part of this update, effective April 1, 2014, HCPCS code L8680 is not included on the 2014 DMEPOS fee schedule file and the coverage indicator is revised to "I" to show it is not payable by Medicare. Note that:

- For neurostimulator devices, HCPCS code L8680 is no longer separately billable for Medicare because payment for electrodes has been incorporated in CPT code 63650 Percutaneous implantation of neurostimulator electrode array, epidural.
- CMS established non-facility practice expense inputs for CPT code 63650 in the Medicare Physician Fee Schedule Final Rule (published November 27, 2013). As a result, practitioners should not report electrode(s) using code L8680 in conjunction with a lead implantation procedure furnished in any setting for Medicare.
- Also, this change for code L8680 will be available on the HCPCS Quarterly Update website at **http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html** on the CMS website.

Additional Information

The official instruction, CR8645, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2902CP.pdf** on the CMS website. If you have any questions, please contact your 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.

July 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8748) (DRU)

MLN Matters® Number: MM8748
Related CR Release Date: April 25, 2014
Related CR Transmittal #: R2936CP

Related Change Request (CR) #: CR 8748
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

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

Provider Action Needed

MACs will use the July 2014 Average Sales Price (ASP) and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2014, with dates of service July 1, 2014, through September 30, 2014.

Change Request (CR) 8748, from which this article is taken, instructs MACs to implement the July 2014 ASP Medicare Part B drug pricing file for Medicate Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised April 2014, January 2014, October 2013, and July 2013 ASP drug pricing files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS supplies the MACs with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "*Medicare Claims Processing Manual*" (Chapter 4, Section 50 (Outpatient PRICER)) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf** on the CMS website.

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

Files	Effective for Dates of Service
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
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013

Additional Information

The official instruction, CR 8748 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2936CP.pdf** on the CMS website.

Chapter 29 Appeals Update (Includes Post-DOMA Guidance and Signature Requirement for Appointment of Representatives and Assignment of Appeal Rights) (MM8588) (GEN)

MLN Matters® Number: MM8588
Related CR Release Date: April 11, 2014
Related CR Transmittal #: R2926CP
Related Change Request (CR) #: CR 8588
Effective Date: July 14, 2014
Implementation Date: July 14, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8588, which updates the "Medicare Claims Processing Manual" (Chapter 29 (Appeals of Claims Decisions)) with various policy clarifications. Make sure that your billing staffs are aware of these updates.

Background

Change Request (CR) 8588 revises the "*Medicare Claims Processing Manual*" (Publication 100-04, Chapter 29 (Appeals of Claims Decisions)) and adds various policy clarifications regarding appeals of claims decisions. These revisions include:

- A definition of spouse following the June 2013 Supreme Court ruling that invalidated Section 3 of the *Defense of Marriage Act* (DOMA) (Section 110);
- Clarification of existing instructions regarding:
  - The submission of appointment of representative written instruments (Section 270.1.3);
  - The handling and reporting of defective or missing appointment instruments (Section 270.1.6); and
  - Signature requirements for appointment of representative instruments (Section 270.1.2).

A copy of the revised "*Medicare Claims Processing Manual*" (Chapter 29 (Appeals of Claims Decisions)) is included as an attachment to CR 8588.

Additional Information

The official instruction, CR 8588, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2926CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/** on the CMS website.

Claim Status Category and Claim Status Codes Update (MM8684) (GEN)

MLN Matters® Number: MM8684
Related CR Release Date: May 23, 2014
Related CR Transmittal #: R2967CP

Related Change Request (CR) #: CR 8684
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

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 Medicare Administrative Contractors (DME MACs) and Home Health & Hospice MACs (HH&H MACs), for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8684 which informs the MACs of the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

Background

The *Health Insurance Portability and Accountability Act* (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/** and **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/** on the Internet.

All code changes approved during the June 2014 committee meeting will be posted on these sites on or about July 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes will be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR8684.

Additional Information

The official instruction, CR8684 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2967CP.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.

Clarification to Pub. 100-02, Medicare Benefit Policy Manual Regarding Antigens and Deletion of Section 13.14 from Chapter 13 of Pub. 100-08, Medicare Program Integrity Manual (CR8665) (GEN)

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 510	**Date: April 11, 2014**
	Change Request 8665

Transmittal 510 is being re-issued to change the Implementation Date from July 14, 2014 to May 12, 2014. The transmittal number, issue date and all other information remain the same.

SUBJECT: Clarification to Pub. 100-02, Medicare Benefit Policy Manual Regarding Antigens and Deletion of Section 13.14 from Chapter 13 of Pub. 100-08, Medicare Program Integrity Manual

I. SUMMARY OF CHANGES: This change request serves to make the Medicare Benefit Policy Manual provisions consistent with regulatory requirements. Additionally, revisions are being made to Chapter 13 of the Program Integrity Manual to accurately reflect CMS's plan to implement section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

EFFECTIVE DATE: January 1, 2001 - (Antigen Update); February 24, 2014 - (Section 13.14 deletion)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 12, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	13/13.14/Evaluation of Local Coverage Determination (LCD) Topics for National Coverage Determination (NCD) Consideration

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts

allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 510	Date: April 11, 2014	Change Request: 8665

Transmittal 510 is being re-issued to change the Implementation Date from July 14, 2014 to May 12, 2014. The transmittal number, issue date and all other information remain the same.

SUBJECT: Clarification to Pub. 100-02, Medicare Benefit Policy Manual Regarding Antigens and Deletion of Section 13.14 from Chapter 13 of Pub. 100-08, Medicare Program Integrity Manual

EFFECTIVE DATE: January 1, 2001 - (Antigen Update); February 24, 2014 - (Section 13.14 deletion)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 12, 2014

I. GENERAL INFORMATION

A. Background: This change request is to ensure that chapter 13 of the Program Integrity Manual accurately reflects CMS's plan to implement section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Therefore, section 13.14 of chapter 13 of the Program Integrity Manual is being deleted.

B. Policy: Section 731 of the MMA called for the Secretary to establish a plan to evaluate new local coverage determinations (LCDs) for national coverage. CMS currently has in place a more efficient process to evaluate new and current LCDs that includes extensive engagement and collaboration through conference calls, face to face meetings and open communication with and among the Medicare Administrative Contractors (MACs) and CMS central office. The MACs evaluate LCDs and the evidence supporting the LCDs using the various tools CMS has available. Under this paradigm, LCDs, where appropriate, are becoming more consistent across MACs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-Systems Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
8665 - 08.1	Contractors shall be aware of the deletion of section 13.14 of chapter 13 in Pub. 100-08, to ensure it accurately reflects CMS's plan to implement section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8665 - 08.2	CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Marie Casey, 410-786-7861 or **marie.casey@cms.hhs.gov** (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Clarification to Pub. 100-02, Medicare Benefit Policy Manual Regarding Antigens and Deletion of Section 13.14 from Chapter 13 of Pub. 100-08, Medicare Program Integrity Manual (CR8665) (GEN)

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 186	Date: April 16, 2014
	Change Request 8665

Transmittal 184, dated April 11, 2014, is being rescinded and replaced by Transmittal 186 to correct the Effective Date in the Pub. 100-02 manual instruction to January 1, 2001. All other information remains the same.

SUBJECT: Clarification to Pub. 100-02, Medicare Benefit Policy Manual Regarding Antigens and Deletion of Section 13.14 from Chapter 13 of Pub. 100-08, Medicare Program Integrity Manual

I. SUMMARY OF CHANGES: This change request serves to make the Medicare Benefit Policy Manual provisions consistent with regulatory requirements. Additionally, revisions are being made to Chapter 13 of the Program Integrity Manual (PIM) to accurately reflect CMS's plan to implement section 731 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

EFFECTIVE DATE: January 1, 2001 - (Antigen Update); February 24, 2014 - (Section 13.14 deletion)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 12, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/50/4.4.1/Antigens
R	16/90/Routine Services and Appliances

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 186	Date: April 16, 2014	Change Request: 8665

Transmittal 184, dated April 11, 2014, is being rescinded and replaced by Transmittal 186 to correct the Effective Date in the Pub. 100-02 manual instruction to January 1, 2001. All other information remains the same.

SUBJECT: Clarification to Pub. 100-02, Medicare Benefit Policy Manual Regarding Antigens and Deletion of Section 13.14 from Chapter 13 of Pub. 100-08, Medicare Program Integrity Manual

EFFECTIVE DATE: January 1, 2001 - (Antigen Update); February 24, 2014 - (Section 13.14 deletion)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 12, 2014

I. GENERAL INFORMATION

A. Background: Section 1861(s)(2)(G) the Social Security Act (the Act) authorizes Medicare coverage of "antigens (subject to quantity limitations prescribed in regulations by the Secretary)". Implementing regulations were established at 42 CFR 410.68 to identify a reasonable supply of antigens is considered to be not more than a 12-month supply.

B. Policy: This change request serves to make the Medicare Benefit Policy Manual provisions regarding a reasonable supply of antigens consistent with the regulatory requirements mentioned above.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-Systems Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
8665 - 02.1	Contractors shall be aware of the corrections in Pub. 100-02, chapter 15, section 50.4.4.1 and chapter 16, section 90, to align with 42 CFR 410.68, which identifies a reasonable supply of antigens is considered to be not more than a 12-month supply of antigens that has been prepared for a particular patient at any one time. **NOTE:** All other aspects of these sections remain the same.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8665 - 02.2	CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cheryl Gilbreath, 410-786-5919 or **Cheryl.Gilbreath@cms.hhs.gov** (Coverage), Wanda Belle, 410-786-7491 or **wanda.belle@cms.hhs.gov** (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual
Chapter 15 - Covered Medical and Other Health Services

50.4.4.1 - Antigens
(Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14)

Payment may be made for a reasonable supply of antigens that have been prepared for a particular patient if: (1) the antigens are prepared by a physician who is a doctor of medicine or osteopathy, and (2) the physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.

Antigens must be administered in accordance with the plan of treatment and by a doctor of medicine or osteopathy or by a properly instructed person (who could be the patient) under the supervision of the doctor. The associations of allergists that CMS consulted advised that a reasonable supply of antigens is considered to be not more than a 12-*month* supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See §§20.2 and 50.2.)

Medicare Benefit Policy Manual
Chapter 16 - General Exclusions From Coverage

90 - Routine Services and Appliances
(Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14)
Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The routine physical checkup exclusion does not apply to the following services (as noted in section 42 CFR 411.15(a)(1)):

- Screening mammography,
- Colorectal cancer screening tests,
- Screening pelvic exams,
- Prostate cancer screening tests,
- Glaucoma screening exams,
- Ultrasound screening for abdominal aortic aneurysms (AAA),
- cardiovascular disease screening tests,
- diabetes screening tests,
- screening electrocardiogram,
- Initial preventive physical examinations,
- Annual wellness visits providing personalized prevention plan services, and
- Additional preventive services that meet the criteria specified in 42 CFR 410.64.

If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, “Black Lung Benefits,” the service is not covered under Medicare and the claimant should be advised to contact their Social Security office regarding the filing of a claim for reimbursement under the “Black Lung” program.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians’ services (and services incident to a physicians’ service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ - the lens of the eye. (See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §120).

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

A. Immunizations

Vaccinations or inoculations are excluded as immunizations unless they are either:

- Directly related to the treatment of an injury or direct exposure to a disease or condition, such as antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. (In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered.); or

- Specifically covered by statute, as described in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

B. Antigens

Prior to the Omnibus Reconciliation Act of 1980, a physician who prepared an antigen for a patient could not be reimbursed for that service unless the physician also administered the antigen to the patient. Effective January 1, 1981, payment may be made for a reasonable supply of antigens that have been prepared for a particular patient even though they have not been administered to the patient by the same physician who prepared them if:

- The antigens are prepared by a physician who is a doctor of medicine or osteopathy, and

- The physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.

A reasonable supply of antigens is considered to be not more than a 12-*month* supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.1)

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 - February 1, 2014 version 3.0.4 (MM8651) (GEN)

MLN Matters® Number: MM8651 Revised
Related CR Release Date: April 10, 2014
Related CR Transmittal #: R1370OTN

Related Change Request (CR) #: CR 8651
Effective Date: May 27, 2014 for DME MACs
Implementation Date: May27, 2014 for DME MACs

Note: *This article was revised on April 11, 2014, to reflect the revised CR8651 issued on April 10. The effective and implementation dates for the DME MACs are revised. Also the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8651 which informs MACs to update the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule per the spreadsheets attached to CR8651. Make sure that your billing staffs are aware of these changes, which introduce a number of new and modified CARC and RARC codes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was implemented 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 *Social Security Act*, requiring the Secretary of the HHS 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.

CR 8651 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. For more detailed information on the codes, see the attachment to CR8651, which contains a number of spreadsheets detailing the changes for July, 2014. CR8651 is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1370OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

CAQH CORE has published Code Combination version 3.0.4 on February 1, 2014. This update is based on the November 1, 2013 CARC and RARC updates as posted at the 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.

Note: Per ACA 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, CR 8651 issued to your DME MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1370OTN.pdf** on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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 - June 1, 2014 version 3.0.5 (MM8711) (GEN)

MLN Matters® Number: MM8711
Related CR Release Date: May 2, 2014
Related CR Transmittal #: R1378OTN

Related Change Request (CR) #: CR 8711
Effective Date: September 2, 2014
Implementation Date: September 2, 2014

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated on October 6, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (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*.

Health Insurance Portability and Accountability Act (HIPAA) amended the *Social Security Act* by adding Part C - Administrative Simplification - to Title XI of the *Social Security Act*, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CAQH CORE will publish the next version of the Code Combination List on or about June 1, 2014. This update is based on March 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.)

Note: Per the *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, CR 8711, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1378OTN.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?

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

MLN Matters® Number: MM8518 Revised
Related CR Release Date: March 18, 2014
Related CR Transmittal #: R1360OTN

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

Note: *This article was revised on March 19, 2014, to reflect a new Change Request (CR). The CR was revised to include two attachments for V3.0.3 and V 3.0.4 of the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE), Mandated CARC/RARC Code Combination List.* ***Version 3.0.4, published January 31, 2014, must be implemented no later than May 1, 2014.*** *The attachment of document V 3.0.3 shows the changes made between Version 3.0.2 and 3.0.3. The attachment of document V 3.0.4 shows the changes made between V 3.0.3 to V 3.0.4.* ***Additionally, the implementation date for V 3.0.4 for Part A and Part B MACs has been delayed to May 5, 2014.*** *The CR release date, transmittal number and link to the CR were also change. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8518, from which this article is taken, instructs Medicare contractors to report only the code combinations that are listed in the current version of the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of CARC and RARC Rule. The spreadsheet attached to CR8518 (which is available also at **http://www.caqh.org/CORECodeCombinations.php**) shows the change log for CORE Code Combination Version 3.0.3 updates published on October 1, 2013.

Background

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

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

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

Additional Information

The official instruction, CR 8518 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1360OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

Implementation of Fingerprint-Based Background Checks (SE1417) (GEN)

MLN Matters® Number: SE1417
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for providers and suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Home Health and Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 640 of the *Affordable Care Act*.

What You Need to Know

Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. Note that the high level of risk category will be applied to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers or Home Health Agencies (HHA). It will also be applied to providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.

What You Need to Do

See the Background and Additional Information Sections of this article for further details.

Background

As part of the enhanced enrollment screening provisions contained in the *Affordable Care Act* (see **http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf**), the Centers for Medicare & Medicaid Services (CMS) is implementing fingerprint-based background checks. The fingerprint-based background checks will be used to detect bad actors who are attempting to enroll in the Medicare program and to remove those currently enrolled. Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category.

Please refer to 42 CFR 424.518(c)(3) at **http://www.ecfr.gov/cgi-bin/text-idx?SID=a39ae0804106965d82b5ae6413ba550e&node=42:3.0.1.1.11.12.5.11&rgn=div8** on the Internet and the "*Medicare Program Integrity Manual*" (Chapter 15 (Medicare Enrollment), Section 15.19.2.1C (Screening Categories-Background-High)) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf** on the CMS website.

Note: The high level of risk category will be applied to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers or Home Health Agencies (HHA). It will also apply to providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.

The fingerprint-based background check implementation will be phased in beginning in 2014. Initially, not all providers and suppliers in the "high" level of risk category will be a part of the fingerprint-based background check requirement.

Applicable providers and suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a notification letter to the applicable providers or suppliers listing all 5% or greater owners who are required to be fingerprinted. The notification letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare. Generally, an individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed.

The relevant individuals will have 30 days from the date of the notification letter to be fingerprinted. If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The notification letter will identify contact information for the Fingerprint-Based Background Check Contractor (FBBC). The relevant individual(s) are required to contact the FBBC prior to being fingerprinted to ensure the fingerprints are accurately submitted to the Federal Bureau of Investigation (FBI) and results are properly returned to CMS. Providers/suppliers may contact the FBBC by telephone or by accessing the FBBC's website. Contact information for the FBBC will be provided in the notification letter received from the MAC. Once contacted, the FBBC will provide at least three fingerprint locations convenient to the relevant individual's location. One of these locations will be a local, state, or federal law enforcement facility.

The relevant individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken, and the cost may vary depending on location. Once an individual has submitted his/her fingerprints, if that individual is subsequently required to undergo a fingerprint-based background check in accordance with 42 CFR 424.518(c), CMS will, to the extent possible, rerun the fingerprint-based background check rather than requiring resubmission of fingerprints. You can review 42 CFR 424.518(c) at **http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.11&rgn=div8** on the Internet.

Fingerprinting can be completed on the FD-258 form or electronically at certain locations. CMS strongly encourages all required applicants to provide electronic fingerprints, but CMS will accept the FD-258 card instead. If the FD-258 form is submitted, the FBBC will convert the paper form to electronic submission to the FBI. You can review the FD-258 form at **http://www.fbi.gov/about-us/cjis/criminal-history-summary-checks/standard-fingerprint-form-fd-258** on the Internet.

Once the fingerprint process is complete, the fingerprints will be forwarded to the FBI for processing. Within 24 hours of receipt, the FBI will compile the background history based on the fingerprints and will share the results with the FBBC. CMS, through the FBBC, will assess the law enforcement data provided for the fingerprinted individuals. The FBBC will review each record and provide a fitness recommendation to CMS. CMS will assess the recommendation and make a final determination.

All fingerprint data will be stored according to:

- Federal requirements;
- FBI Security and Management Control Outsourcing Standards for Channelers and Non-Channelers; and
- The FBI Criminal Justice Information Services (CJIS) Security Policy.

The FBBC will maintain *Federal Information Systems Management Act* (FISMA) certification and comply with the FBI (CJIS) Security Policy. All data will be secured in accordance with the *Privacy Act* of 1974 and the FBI CJIS Security Policy.

CMS will rely on existing authority to deny enrollment applications and revoke existing Medicare billing privileges per 42 CFR §424.530(a) and §424.535(a) (**http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.15&rgn=div8**) if an individual who maintains a 5% or greater direct or indirect ownership interest in a provider or supplier has submitted an enrollment application that contains false or misleading information. Providers or suppliers will be notified by CMS if the assessment of the fingerprint based background check results in the denial of its enrollment application or revocation of its existing Medicare billing privileges.

Additional Information

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.

Implementation of National Automated Clearinghouse Association (NACHA) Operating Rules for Health Care Electronic Funds Transfers (EFT) (MM8629) (GEN)

MLN Matters® Number: MM8629 Revised
Related CR Release Date: April 9, 2014
Related CR Transmittal #: R1367OTN

Related Change Request (CR) #: CR 8629
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Note: *This article was revised on April 10, 2014, to reflect changes made to CR8629 on April 9. In the article, the transmittal number, CR release date, and the Web address for 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 Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR8629 which informs MACs that they must comply with National Automated Clearinghouse Association (NACHA) Operating Rules that are applicable to initiators of health care payments. CR8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the Automated Clearinghouse (ACH) Electronic Funds Transfer (EFT) Network with electronic health care payments.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR8629 can be accommodated by your accounting processes and systems.

Background

In support of *Health Insurance Portability & Accountability Act* of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA - The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration, and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

The new NACHA standard that applies to health care payments took effect on September 20, 2013. Some of the NACHA Operating Rules that apply to health care payments apply to "Originators" of those payments, which include the health plans, payers, or their business associates.

A specific NACHA Operating Rule that applies to Originators - and is distinct from related HIPAA requirements - is the requirement to clearly identify CCD (Cash Concentration or Disbursement) Entries that are Healthcare EFT Transactions using a specific identifier.

The Healthcare EFT Standard requires that the Company Entry Description field contains "HCCLAIMPMT" to identify the payment as healthcare.

Additional Information

For information on the NACHA Operating Rules that apply to health care payments, particularly with regard to requirements for originators, see **https://healthcare.nacha.org/healthcarerules** on the Internet.

The official instruction, CR8629 issued to your MAC regarding this change may be viewed at

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1367OTN.pdf on the CMS website.

You may also want to view article MM8619 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8619.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.

Indirect Payment Procedure (IPP) - Payment to Entities that Provide Coverage Complementary to Medicare Part B (MM8638) (GEN)

MLN Matters® Number: MM8638
Related CR Release Date: March 7, 2014
Related CR Transmittal #: R2896CP

Related Change Request (CR) #: CR 8638
Effective Date: June 6, 2014
Implementation Date: June 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and other applicable entities submitting claims using the indirect payment procedure to Part B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

What You Need to Know

The article is based on Change Request (CR) 8638, which updates the manual instructions regarding the indirect payment procedure policy in the "*Medicare Claims Processing Manual*," Chapter 1, Section 30.2.8.3.

Section 1842(b)(6)(B) of the *Social Security Act*, as well as the Medicare regulations at 42 Code of Federal Regulations (CFR) Section 424.66, specify that payment may be made to an entity for Part B services furnished by a physician or other supplier under a complementary health benefit plan if the entity meets certain requirements. This process is known as the indirect payment procedure (IPP).

According to Chapter 1, Section 30.2.8.3 of the "*Medicare Claims Processing Manual*", because Section 1842(h)(1) of the *Social Security Act* only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" as described in 42 CFR. 400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95 percent of the physician fee schedule amount.

Payment under the IPP can only be made for covered Part B services. If an IPP entity submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his/her claim), then Medicare cannot make payment to the physician for that same service. Medicare payment can only be made once for a beneficiary's specific service. Therefore, claims for services that have already been billed to Medicare shall be denied (with appeal rights) by Medicare's contractors.

In addition, Medicare payment cannot be made under the IPP for services that are payable for a particular beneficiary under any other Part of Medicare. For example, if a beneficiary's service is payable under Part C and a Medicare Advantage organization is also an IPP entity under 42 CFR 424.66, then a Medicare Part B payment under the IPP cannot be made to that Medicare Advantage organization for that beneficiary's service. In these types of dual or multiple enrollment situations, services that are payable under those other Parts of Medicare (e.g., Parts C or D) cannot also be billed and paid for under Part B. Therefore, IPP entities that submit Part B claims for services that are payable under another Part of Medicare (e.g., Part C or D) shall be denied (with appeal rights) by Medicare's contractors.

Payment for IPP claims by Medicare is conditioned upon the claim and the underlying transaction complying with the Medicare laws, regulations, and program instructions applicable to IPP entities, and on the IPP entity's continued compliance with the regulatory requirements described in 42 CFR 424.66.

Medicare's IPP policy states that Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

1) Provides coverage of the service under a complementary health benefit plan (that is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

3) Has the written authorization of the beneficiary or of a person authorized to sign claims on the beneficiary's behalf under 42 CFR 424.36 to receive the Part B payment for the services for which the entity pays.

4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, or from the beneficiary's survivors or estate.

5) Submits any information the Centers for Medicare & Medicaid Services (CMS) or the MAC may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that satisfy all of the requirements above may include employers, unions, insurance companies, and retirement homes. They also may include health care prepayment plans, health maintenance organizations (HMOs), competitive medical plans, and Medicare Advantage organizations.

The IPP permits a physician or supplier to file a single claim with the complementary insurer and receive full payment in a single payment, relieves the beneficiary of the need to file a claim, and protects the beneficiary against any financial liability for the service.

In addition, any entity wishing to bill using the IPP must register through Provider Enrollment and meet such requirements specified in the "*Medicare Program Integrity Manual*," Chapter 15, Sections 15.7.9 through 15.7.9.7. This part of the manual is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf** on the CMS website.

Additional Information

The official instruction, CR 8638, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2896CP.pdf** on the CMS website. If you have any questions, please contact your 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.

ICD-10 Compliance Date and End-to-End Testing Information on Page 41

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

MLN Matters® Number: MM8401 Revised
Related CR Release Date: May 13, 2014
Related CR Transmittal #: R2955CP

Related Change Request (CR) #: CR 8401
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Note: *This article was revised on May 15, 2014, to reflect the revised CR8401 issued on May 13. The article has been revised to delete information regarding entry of the clinical trial number on institutional paper or Direct Data Entry (DDE) claim UB-04. Also, the transmittal number, the CR release date, 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 contractors (Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider Action Needed

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

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

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

Background

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

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

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

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

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

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

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

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and

- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

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

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

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

Additional Information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2955CP.pdf** on the CMS website.

See MLN Matters® Article SE1344 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1344.pdf**) for information on an interim alternative method of satisfying the requirement in CR 8401 for providers who do not have the ability to submit the clinical trial number for trial related claims.

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.

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2014 (MM8702) (GEN)

MLN Matters® Number: MM8702
Related CR Release Date: May 1, 2014
Related CR Transmittal #: R2940CP

Related Change Request (CR) #: CR 8702
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

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) 8702 to provide the DMEPOS Competitive Bidding Program (CBP) July 2014 quarterly update. CR8702 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

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 (CBAs). 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 Metropolitan Statistical Areas (MSAs) in 2007. The *Medicare Improvements for Patients and Providers Act* of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS conducted the supplier competition again in nine areas in 2009, referring to it as the Round 1Rebid. The Round 1 Rebid contracts and prices became effective on January 1, 2011.

MIPPA also delayed the competition for Round 2 from 2009 to 2011 and authorized national mail order competitions after 2010. The *Affordable Care Act* of 2010 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 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 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.) On January 1, 2014, new contracts for the Round 1 Recompete became effective in the same CBAs as the Round 1 Rebid.

Additional Information

The official instruction, CR 8702 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2940CP.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.

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

MLN Matters® Number: MM8676
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

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.

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.

Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) and Medicare Remit Easy Print (MREP) and PC Print Update (MM8703) (GEN)

MLN Matters® Number: MM8703
Related CR Release Date: April 4, 2014
Related CR Transmittal #: R2920CP

Related Change Request (CR) #: CR 8703
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8703, which updates the Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare systems maintainers to update the Medicare Remit Easy Print (MREP) and PC Print by July 1, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software if you use that software.

Background

The *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Accordingly, Medicare policy states that CARCs and appropriate RARCs must be used for:

- Transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, along with Group Code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits).

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or use another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. CARC and RARC code sets are updated three times a year on a regular basis. CR 8703 lists only the changes that have been approved since the last code update (CR 8561, Transmittal 2855, issued on January 10, 2014, with the related MLN Matters® article available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8561.pdf** on the CMS website), and does not provide a complete list of codes for these two code sets.

Changes in CARC List since CR 8561

The following tables list the changes in the CARC database since the last code update in CR8561. The full CARC list is available from the Washington Publishing Company (WPC) website at **http://wpc-edi.com/Reference** on the Internet.

New Codes - CARC

Code	Narrative	Effective Date
259	Additional payment for Dental/Vision service utilization.	01/26/2014
260	Processed under Medicaid ACA Enhanced Fee Schedule.	01/26/2014

Modified Codes - CARC

Code	Modified Narrative	Effective Date
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) Notes: To be used for months 2 and 3 in the grace period.	01/26/2014

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
A7	Presumptive Payment Adjustment	07/01/2015

Changes in RARC List since CR 8561

The following tables list the changes in the RARC database since the last code update in CR8561. The full RARC list is available from the WPC website at **http://wpc-edi.com/Reference** on the Internet.

New Codes - RARC

Code	Narrative	Effective Date
N699	Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.	3/1/2014
N700	Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.	3/1/2014
N701	Payment adjusted based on the Value-based Payment Modifier.	3/1/2014
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services	3/1/2014
N703	This service is incompatible with previously adjudicated claims or claims in process.	3/1/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	3/1/2014
N705	Incomplete/invalid documentation.	3/1/2014
N706	Missing documentation.	3/1/2014
N707	Incomplete/invalid orders.	3/1/2014
N708	Missing orders.	3/1/2014
N709	Incomplete/invalid notes.	3/1/2014
N710	Missing notes.	3/1/2014
N711	Incomplete/invalid summary.	3/1/2014
N712	Missing summary.	3/1/2014
N713	Incomplete/invalid report.	3/1/2014
N714	Missing report.	3/1/2014

Code	Narrative	Effective Date
N715	Incomplete/invalid chart	3/1/2014
N716	Missing chart.	3/1/2014
N717	Incomplete/Invalid documentation of face-to-face examination	3/1/2014
N718	Missing documentation of face-to-face examination.	3/1/2014
N719	Penalty applied based on plan requirements not being met.	3/1/2014
N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.	3/1/2014
N721	This service is only covered when performed as part of a clinical trial.	3/1/2014
N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.	3/1/2014
N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.	3/1/2014
N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.	3/1/2014
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N726	A conditional payment is not allowed.	3/1/2014
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014

Modified Codes - RARC

Code	Modified Narrative	Effective Date
MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number. Start: 01/01/1997. Last modified: 03/01/2014. Notes: (Modified 2/28/03, 3/1/2014)	3/1/2014
M77	Missing/incomplete/invalid/inappropriate place of service. Start: 01/01/1997. Last Modified: 03/01/2014. Notes: (Modified 2/28/03, 3/1/2014)	3/1/2014
N29	Missing documentation/orders/notes/summary/report/chart. Start: 01/01/2000 | Stop: 03/01/2016 | Last Modified: 03/01/2014. Notes: (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014
N225	Incomplete/invalid documentation/orders/ notes/summary/report/ chart. Start: 08/01/2004 | Stop: 03/01/2016 | Last Modified: 03/01/2014. Notes: (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014

Deactivated Codes - RARC (There are no deactivated codes.)

Additional Information

The official instruction, CR 8703, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2920CP.pdf** on the CMS website. If you have any questions, please contact your 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.

Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category (MM8566) (GEN)

MLN Matters® Number: MM8566 Revised
Related CR Release Date: March 25, 2014
Related CR Transmittal #: R1362OTN

Related Change Request (CR) #: CR 8566
Effective Date: April 1, 2014
Implementation: April 7, 2014

Note: *This article was revised on April 8, 2014, to add a note on page 4 that states Medicare policy for DME items needed during a covered Part A stay in a skilled nursing facility (SNF). The note is a clarification and does not change existing policies. The effective date for the Power Wheelchair Accessories on page 3 was corrected to April 1, 2014. In addition, further clarification of affected providers was added below (bold). All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries. **In addition, this MLN Matters® Article is intended to clarify the interaction between these Part B coding changes and the bundled Part A payment that SNFs receive for a resident's Medicare-covered stay.**

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8566 as a one-time notification that provides instructions regarding the reclassification of certain DME from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category for the Healthcare Common Procedure Coding System (HCPCS) codes listed in 'Attachment A' of CR8566. Be sure your billing personnel are aware of these changes.

Background

DME and accessories used in conjunction with DME are paid for under the DME benefit and in accordance with the rules at section 1834(a) of the *Social Security Act* (the Act). The Medicare definition of routinely purchased durable medical equipment (DME) set forth at 42 CFR 414.220(a)(2) specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989, that is, new codes added to the HCPCS after 1989 for items costing more than $150, showed inconsistencies in applying the definition. As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. CMS-1526-F is available at **http://www.gpo.gov/fdsys/pkg/FR-201312-02/pdf/2013-28451.pdf** on the Internet.

Also in the rule, CMS established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 - K0864) are payable under the lump sum purchase method. The complex rehabilitative power wheelchair base codes and options/accessories are payable under the lump sum purchase method set forth at 42 CFR 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Act.

In order to align the payment category with the required regulatory definition, certain HCPCS codes listed in Attachment A will reclassify from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category. Instructions for billing capped rental items can be found at "*Medicare Claims Processing Manual*" (Pub. 100-04), Chapter 20, Section 130.9 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf** along with other sources listed on the CMS and contractor websites.

Be aware the effective date is April 1, 2014 for HCPCS codes not included in a Competitive Bidding Program (CBP) as shown in Attachment A of CR8566. A forthcoming CR will address the codes that are reclassifying to the capped rental payment category effective July 1, 2016, and January 1, 2017.

As shown in the table below, HCPCS codes for items included under the Round 2 and/or Round 1 Recompete DMEPOS CBPs will transition to the capped rental payment category in stages.

Payment Category Transition Effective Dates	
April 1, 2014	HCPCS codes not included in a CBP are reclassified from IN DME to CR DME in all areas
July 1, 2016	HCPCS codes included in a CBP are reclassified from IN DME to CR DME in all areas except the 9 Round 1 Recompete CBAs, where items furnished to beneficiaries residing in these areas will remain in, IN DME through December 31, 2016
January 1, 2017	HCPCS codes included in a CBP are reclassified from IN DME to CR DME in the 9 Round 1 Recompete CBAs

When the HCPCS codes listed below are furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete CBP, the payment category transition from inexpensive and routinely purchased to capped rental DME is effective January 1, 2017.

HCPCS for Items Reclassified to Capped Rental DME Category Effective July 1, 2016*	
Support Surfaces	E0197
Walkers	E0140 & E0149
Wheelchairs Options/Accessories	E0985, E1020, E1028, E2228, E2368, E2369, E2370,E2375, K0015, K0070
Wheelchair Seating	E0955

* Items furnished in accordance with Round 1 Recompete contracts reclassify effective January 1, 2017

Complex Rehabilitative Power Wheelchair Accessories

Effective April 1, 2014, for wheelchair accessory codes classified under the capped rental DME payment category and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair), the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. These accessory items would be considered as part of the complex rehabilitative power wheelchair (codes K0835 - K0864) and associated lump sum purchase option set forth at 42 CFR 414.229(a)(5).

If the beneficiary declines the purchase option, the supplier must furnish the items on a rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

Note: Items Needed During a Covered Part A Stay in a SNF

For an SNF resident whose stay is covered by Part A of Medicare, the extended care benefit provides comprehensive coverage for the overall package of institutional care that the SNF furnishes. This coverage includes any medically necessary durable medical equipment (DME) under the heading of ". . . drugs, biologicals, supplies, appliances, and equipment . . ." (section 1861(h)(5) of the *Social Security Act* (the Act)).

Accordingly, in cases where such a resident has a medical need for DME during the course of the Part A stay, the SNF is obligated to furnish it, since the SNF's global per diem payment for the covered stay itself already includes any medically necessary DME.

Prior to April 1, 2014, and the change in Medicare Part B payment rules addressed in this article, Medicare beneficiaries may have brought this equipment purchased under Part B with them for use during a covered Part A stay in a SNF. This may still be the case for beneficiaries who take over ownership of the equipment after 13 months of continuous Part B rental payments.

However, in those cases where the beneficiary enters a SNF under a covered Part A stay and is in the middle of the 13-month capped rental period under Part B for the item, it is the responsibility of the SNF to ensure that the beneficiary has access to this equipment if it is medically necessary while the beneficiary is in the SNF during the Part A stay.

Additional Information

The official instruction, CR 8566 along with Attachment A, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1362OTN.pdf** on the CMS website. Attachment A is also repeated at the end of this article. 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/MonitoringPrograms/provider-compliance-interactive-map/index.html** on the CMS website.

Attachment A

Inexpensive & Routinely Purchased (IN) Items Reclassified to Capped Rental (CR)

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
Automatic External Defibrillator	K0607	Repl battery for AED	[redacted]		
Canes/Crutches	E0117	Underarm spring assist crutch	[redacted]		
Glucose Monitor	E0620	Capillary blood skin piercing device laser	[redacted]		
High Frequency Chest Wall Oscillation Device (HFCWO)	A7025	Replace chest compress vest	[redacted]		
Hospital Beds/Accessories	E0300	Enclosed ped crib hosp grade	[redacted]		
Misc. DMEPOS	A4639	Infrared ht sys replacement pad	[redacted]		
	E0762	Trans elec jt stim dev sys	[redacted]		
	E1700	Jaw motion rehab system	[redacted]		
Nebulizers & Related Drugs	K0730	Ctrl dose inh drug deliv system	[redacted]		
Other Neuromuscular Stimulators	E0740	Incontinence treatment system	[redacted]		
	E0764	Functional neuromuscular stimulation	[redacted]		
Pneumatic Compression Device	E0656	Segmental pneumatic trunk	[redacted]		
	E0657	Segmental pneumatic chest	[redacted]		
Power Operated Vehicles	E0984	Add pwr tiller	[redacted]		
Speech Generating Devices	E2500	SGD digitized pre-rec <=8min	[redacted]		
	E2502	SGD prerec msg >8min <=20min	[redacted]		
	E2504	SGD prerec msg>20min <=40min	[redacted]		
	E2506	SGD prerec msg > 40 min	[redacted]		
	E2508	SGD spelling phys contact	[redacted]		
	E2510	SGD w multi methods messg/access	[redacted]		
Support Surfaces	E0197 *	Air pressure pad for mattress		[redacted]	[redacted]
	E0198	Water pressure pad for mattress	[redacted]		
Traction Equipment	E0849	Cervical pneum traction equip	[redacted]		

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
	E0855	Cervical traction equipment	■		
	E0856	Cervical collar w air bladder	■		
Walkers	E0140 *	Walker w trunk support		■	■
	E0144	Enclosed walker w rear seat	■		
	E0149 *	Heavy duty wheeled walker		■	■
Wheelchairs Manual	E1161	Manual adult wc w tiltinspac	■		
	E1232	Folding ped wc tilt-in-space	■		
	E1233	Rig ped wc tltnspc w/o seat	■		
	E1234	Fld ped wc tltnspc w/o seat	■		
	E1235	Rigid ped wc adjustable	■		
	E1236	Folding ped wc adjustable	■		
	E1237	Rgd ped wc adjstabl w/o seat	■		
	E1238	Fld ped wc adjstabl w/o seat	■		
Wheelchair Options/Accessories	E0985 *	W/c seat lift mechanism		■	■
	E0986	Man w/c push-rim pow assist	■		
	E1002 ^	Pwr seat tilt	■		
	E1003 ^	Pwr seat recline	■		
	E1004 ^	Pwr seat recline mech	■		
	E1005 ^	Pwr seat recline pwr	■		
	E1006 ^	Pwr seat combo w/o shear	■		
	E1007 ^	Pwr seat combo w/shear	■		
	E1008 ^	Pwr seat combo pwr shear	■		
	E1010 ^	Add pwr leg elevation	■		
	E1014	Reclining back add ped w/c	■		
	E1020 *	Residual limb support system		■	■
	E1028 *	W/c manual swingaway		■	■
	E1029	W/c vent tray fixed	■		
	E1030 ^	W/c vent tray gimbaled	■		
	E2227	Gear reduction drive wheel	■		
	E2228 *	Mwc acc, wheelchair brake		■	■
	E2310 ^	Electro connect btw control	■		
	E2311 ^	Electro connect btw 2 sys	■		
	E2312 ^	Mini-prop remote joystick	■		
	E2313 ^	PWC harness, expand control	■		
	E2321 ^	Hand interface joystick	■		
	E2322 ^	Mult mech switches	■		
	E2325 ^	Sip and puff interface	■		
	E2326 ^	Breath tube kit	■		
	E2327 ^	Head control interface mech	■		

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
	E2328 ^	Head/extremity control interface	■		
	E2329 ^	Head control interface nonproportional	■		
	E2330 ^	Head control proximity switch	■		
	E2351 ^	Electronic SGD interface	■		
	E2368 *	Pwr wc drivewheel motor replace		■	■
	E2369 *	Pwr wc drivewheel gear box replace		■	■
	E2370 *	Pwr wc dr wh motor/gear comb		■	■
	E2373 ^	Hand/chin ctrl spec joystick	■		
	E2374 ^	Hand/chin ctrl std joystick	■		
	E2375 *	Non-expandable controller		■	■
	E2376 ^	Expandable controller, replace	■		
	E2377 ^	Expandable controller, initial	■		
	E2378	Pw actuator replacement	■		
	K0015 *	Detach non-adjus hght armrest		■	■
	K0070 *	Rear whl complete pneum tire		■	■
Wheelchairs Seating	E0955 *	Cushioned headrest		■	■

* Effective January 1, 2017 if the item is furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete of DMEPOS CBP

^ Item billable with Complex Rehabilitative Power Wheelchair codes K0835 - K0864

Update to Surety Bond Collection Procedures (MM8636) (GEN)

MLN Matters® Number: MM8636
Related CR Release Date: May 16, 2014
Related CR Transmittal #: R517PI

Related Change Request (CR) #: CR 8636
Effective Date: June 17, 2014
Implementation Date: June 17, 2014

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment. Prosthetics, Orthotics and Supplies (DMEPOS) suppliers that submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and are required to obtain and maintain a surety bond as a condition of their enrollment in the Medicare program.

Provider Action Needed

This article is based on Change Request (CR) 8636, which outlines revised procedures to be used in the surety bond collection process. Be certain you are aware of these clarifications.

Background

For purposes of the surety bond requirement, 42 Code of Federal Regulations (CFR) section 424.57(a) defines an "unpaid claim" as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

Key Points of CR8636

The following describe the revised procedures involved in making a claim against a surety bond.

- If 45 days have passed since the initial demand letter was sent to the DMEPOS supplier, full payment has not been received, and the supplier has a surety bond, the DME MAC will (subject to the situations described in Pub. 100-08, chapter 15, section 15.21.7.1(A)(2)(b)(1) through (5)) send an "Intent to Refer" (ITR) letter to the supplier and a copy thereof to the supplier's surety. The letter and copy will be sent no earlier than the 45th day and no later than the 60th day after the initial demand letter was sent.
- If the DME MAC does not receive full payment from the supplier within 30 days of sending the ITR letter (and subject to the situations described in Pub. 100-08, chapter 15, section 15.21.7.1(A)(2)(b)(1) through (5)), the contractor will notify the surety via letter that payment of the claim must be made to CMS within 45 days from the date of the surety letter. The DME MAC will send the surety letter no earlier than 30 days and no later than 75 days after sending the ITR letter.
- Between 8 and 12 calendar days after sending the surety letter, the DME MAC will contact the surety by telephone or e-mail to determine whether the surety received the letter.
- If the surety fails to make full payment within the 45-day timeframe, the DME MAC will (1) continue collection efforts and (2) notify the appropriate Center for Program Integrity (CPI) liaison via e-mail of the surety's failure to make payment.

Additional Information

The official instruction regarding this change, CR 8636, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R517PI.pdf** on the CMS website. Interested parties are strongly encouraged to read this instruction in full, as it contains additional information about the revised collection procedures.

Medicare's surety bond requirements are summarized in detail in article MM6392 at: **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6392.pdf** on the CMS website.

Also, you may want to review MM6854 at **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6854.pdf** which clarifies situations where surety bonds must be reported to the National Supplier Clearinghouse.

If you have any questions, please contact your DME 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.

Updating Beneficiary Information with the Benefits Coordination & Recovery Center (formerly known as the Coordination of Benefits Contractor) (SE1416) (GEN)

MLN Matters® Number: SE1416
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 replaces article SE1205. There are no changes to the processes that were described in SE1205. The key change is that the Coordination of Benefits Contractor (COBC) is now known as the Benefits Coordination and Recovery Center (BCRC) and there is new contact, address, and Web address information at the end of this article that is associated with this process and the BCRC.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare. It updates MLN Matters® Article SE1205 to provide information regarding the Benefits Coordination & Recovery Center (BCRC), which has replaced the former Coordination of Benefits Contractor.

Provider Action Needed

Impact to You

A new Medicare Secondary Payer (MSP) initiative will affect how you may update beneficiary information to the BCRC.

What You Need to Know

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the BCRC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's Common Working File (CWF).

What You Need to Do

You should make sure that your appropriate staffs are aware of these options for updating a beneficiary's MSP information and that they are aware of new contact information at the end of this article for the BCRC.

Background

There has been considerable discussion about the accuracy of beneficiary Medicare Secondary Payer (MSP) information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the BCRC by phone. Therefore (as noted below), CMS and the BCRC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

CMS Initiatives

In compliance with Section 111 of the *Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act* of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both Group Health Plans (GHP) and Non Group Health Plans (NGHP)) submit coverage information to the BCRC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a Responsible Reporting Entity (RRE), and the BCRC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records. This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the BCRC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the BCRC. To reduce such conflicts in the future, CMS has developed and implemented a data management "Reporting Hierarchy" process, which the BCRC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found within the MMSEA Section 111 GHP User Guide available at the BCRC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found within the MMSEA Section 111 GHP User Guide available at the BCRC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found within the MMSEA Section 111 GHP User Guide available at **http://go.cms.gov/MIRGHPUserGuide** on the CMS website.

BCRC Initiatives

The BCRC works closely with GHP RREs and other reporters in order to reduce "hierarchy" conflicts in future reporting. The following steps are in place to help providers update MSP records:

- **Provider attempting update with the beneficiary in the office:**
  The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4, 2011, no update will be made on the call, but two options are available: 1) Proof of information can be faxed or mailed on the insurer or employer's company letterhead, and the update will be made in 10-15 business days; or 2) You can contact the insurer or employer organization that last updated the record.

- **Provider attempting update when the beneficiary is not in the office:**
  No update will be made from a telephone call. The provider has three options to have the record updated:
  1) Have the Beneficiary contact BCRC;
  2) Contact the Beneficiary's insurer to resolve the issue; or
  3) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- **Provider with new information:**
  The BCRC will take new information for a Beneficiary, but if the new information requires changes to an existing record, two options are available:
  1) The Beneficiary will need to call to close out the record; or
  2) Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- **Provider update for deceased beneficiary:**
  A SINGLE update can be made by ONE provider for a Deceased Beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

Additional Information

An explanation of the GHP RRE Hierarchy rules can be found within the MMSEA Section 111 GHP User Guide at **http://go.cms.gov/MIRGHPUserGuide** on the CMS website. General information about GHP Mandatory Insurer Reporting is available at **http://go.cms.gov/mirghp** on the CMS website.

The BCRC's contact information is:
Telephone: 1-855-798-2627 (8 AM to 8 PM Eastern Time)
Fax: 1-405-869-3307 (address the fax to Medicare- MSP General Correspondence)

Mailing address:
Medicare - MSP General Correspondence
P.O. Box 138897
Oklahoma City, OK 73113-8897

CMS MLN Connects e-News: ICD-10 Compliance Date and End-to-End Testing Information (GEN)

ICD-10 Compliance Date

On April 1, 2014, the *Protecting Access to Medicare Act* of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

July ICD-10 End-to-End Testing Canceled: Additional Testing Planned for 2015

CMS planned to conduct ICD-10 testing during the week of July 21 through 25, 2014, to give a sample group of providers the opportunity to participate in end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The July testing has been canceled due to the ICD-10 implementation delay. Additional opportunities for end-to-end testing will be available in 2015.

ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs) - Maintenance CR (MM8691) (GEN)

MLN Matters® Number: MM 8691
Related CR Release Date: May 23, 2014

Related CR Transmittal #: R1388OTN

Related Change Request (CR) #: CR 8691
Effective Date: July 1, 2014 (ICD-9 updates, local system edits), October 1, 2014 (designated ICD-9 shared system edits), October 1, 2015 (or whenever ICD-10 is implemented) (ICD-10 updates)determined for ICD-10
Implementation Date: July 7, 2014 (designated ICD-9 updates, local system edits, October 6, 2014 (or whenever ICD-10 is implemented (ICD-10 updates)to be determined for ICD-10

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 and Hospice MACs (HH&H MACs) and Durable Medical Equipment MACs (DME MACs), for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8691 which is the first maintenance update of ICD-10 conversions and coding updates specific to National Coverage Determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, and CR8197. Links to related MLN Matters® Articles MM7818, MM8109, and MM8197 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly recurring updates. No policy-related changes are included with these recurring updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these changes to the following 29 NCDs:

20.5 ECU Using Protein A Columns, 20.7 PTA, 20.20 ECP Therapy, 20.29 HBO Therapy, 50.3 Cochlear Implants, 70.2.1 Diabetic Peripheral Neuropathy, 80.2 Photodynamic Therapy, 80.2.1 OPT, 80.3 Photosensitive Drugs, 80.3.1 Verteporfin, 100.1 Bariatric Surgery, 110.8.1 Stem Cell Transplants, 110.4 Extracorpreal Photopheresis, 110.10 IV Iron Therapy, 150.3 Bone Mineral Density, 160.18 VNS, 160.24 Deep Brain Stimulation, 160.27 TENS for CLBP, 180.1 MNT, 190.1 Histocompatibility Testing, 190.8 Lymphocyte Mitogen Response Assay, 190.11 Home PT/INR, 210.1 PSA Screening Tests, 210.2 Screening Pap/Pelvic Exams, 210.3 Colorectal Cancer Screens, 210.10 Screening for STIs, 250.4 Treatment for AKs, 250.3 IVIG for Autoimmune Blistering Disease, 250.5 Dermal Injections for Facial LDS

Background

The purpose of CR8691 is to both create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, etc. The requirements described in CR8691 reflect the operational changes that are necessary to implement the conversion of the Medicare systems from ICD-9 to ICD-10 specific to the 29 NCD spreadsheets attached to CR8691.

Additional Information

The official instruction, CR8691 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1388OTN.pdf** on the CMS website. Note that there are 29 spreadsheets attached to CR8691 and those spreadsheets relate to 9 NCDs and provide pertinent policy/coding information necessary to implement ICD-10.

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.

MM7818 is available for review at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7818.pdf** on the CMS website.

MM8109 is available for review at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8109.pdf** on the CMS website.

MM8197 is available for review at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf** on the CMS website.

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

MLN Matters® Number: MM8465
Related CR Release Date: March 7, 2014
Related CR Transmittal #: R1357OTN

Related Change Request (CR) #: CR 8465
Effective Date: December 3, 2013
Implementation Date: March 3, 2014; March 12, 2014 for contractor report to CMS

Note: *This article was revised on April 8, 2014 to add a link SE1409 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1409.pdf**) for additional explanation of CMS' overall testing strategy in implementing ICD-10. All other information is unchanged.*

Provider Types Affected

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

What Providers Need to Know

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

For dates of service of October 1, 2014 (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.

- **Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013 through March 3, 2014), since testing does not support future dated claims.**
- **Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.**

- **Testing will not confirm claim payment or produce remittance advice.**
- **MACs and CEDI will be staffed to handle increased call volume during this week.**

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

Background

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

CR8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week has been created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

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

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

Testing Week Information:

- Your MAC will announce and actively promote the testing week via listserv messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an email address for the trading partners to provide registration information. The registration site or email address information will be available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- **On or before March 12, 2014, your contractor will report the following to CMS:**
    - Number of trading partners conducting testing during the testing week.
    - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
    - Percent of test claims accepted versus rejected.
    - Report of any significant issues found during testing.

Note: *On March 10, 2014, a revised CR changed the due date for the contractor report to CMS to March 12, 2014 (see page 3). This date was also added to the implementation date for this reporting requirement only. The February 27, 2014, change to the article provided additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (**page 2 in bold**).*

Additional Information

The official instruction, CR8465, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1357OTN.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.

International Classification of Diseases, Tenth Revision (ICD-10) Limited End-to-End Testing with Submitters (MM8602) (GEN)

MLN Matters® Number: MM8602 Rescinded
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1352OTN

Related Change Request (CR) #: CR 8602
Effective Date: July 7, 2014
Implementation Date: July 7, 2014

Note: *This article was rescinded on May 7, 2014, since the related CR8602 was rescinded.*

Modifying the Daily Common Working File (CWF) to Medicare Beneficiary Database (MBD) File to Include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 Transactions (MM8456) (GEN)

MLN Matters® Number: MM8456 Rescinded
Related CR Release Date: May 16, 2014
Related CR Transmittal #: R1386OTN

Related Change Request (CR) #: CR 8456
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Note: *This article was rescinded on May 20, 2014, as a result of a revision to CR8456, issued on May 16. The CR revision eliminated the need for provider education. As a result, this article is rescinded.*

Updating Beneficiary Information with the Coordination of Benefits Contractor (SE1205) (GEN)

MLN Matters® Number: SE1205 Rescinded
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 rescinded and replaced by MLN Matters® Article SE1416 on April 3, 2014. That article is available at* **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf** *on the CMS website.*

Fee Schedule Updates (GEN)

The [YEAR] 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:

- 2nd Quarter 2014 Jurisdiction A DME MAC Fee Schedule
- 2nd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2014 Oral Anticancer Drug Fees

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

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

CMS News Flash (GEN)

New products from the Medicare Learning Network® (MLN)

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

- "*Provider Compliance Tips for Computed Tomography (CT Scans)*",
  Fact sheet, ICN 907793, EPUB, QR
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN907793.html

- "*Medicaid Program Integrity: What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs?*",
  Fact Sheet, ICN 901010, Downloadable
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN901010.html

- "*Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 3]*",
  Educational Tool, ICN 909006, Downloadable
  http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN909006.pdf

- "*Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 2]*",
  Educational Tool, ICN 908994, Downloadable
  http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908994.pdf

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

- "*Information on the National Physician Payment Transparency Program: Open Payments*",
  Podcast, ICN 908961, Downloadable
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908961-Podcast.html

Revised products from the Medicare Learning Network® (MLN)

- "*Quick Reference Information: Medicare Immunization Billing*",
  Educational Tool, ICN 006799, Downloadable,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/qr_immun_bill.pdf

- "*Quick Reference Information: Home Health Services*",
  Educational Tool, ICN 908504, Downloadable,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Quick_Reference_Home_Health_Services_Educational_Tool_ICN908504.pdf

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

- "*Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse*",
  Booklet, ICN 907798, EPUB, QR,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf

- "*The DMEPOS Competitive Bidding Program: Non-Contract Supplier*",
  Fact Sheet, ICN 900925, Downloadable,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME-Noncontract-Factsheet-ICN900925.pdf

- "*Communicating With Your Medicare Patients*",
  Fact Sheet, ICN 908063, Hard Copy,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Communicating_With_Patients_Fact-_Sheet_ICN908063.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

- "*End-Stage Renal Disease Prospective Payment System*",
  Fact Sheet, ICN 905143, Downloadable,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/End-Stage_Renal_Disease_Prospective_Payment_System_ICN905143.pdf

- "*Telehealth Services*",
  Fact sheet, ICN 901705,
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

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

September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions

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

MLN Educational Products Electronic Mailing List

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

Flu Vaccination and its Administration

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.
- Free Resources (**http://wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx**) can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under "Programs", select "Immunizations and Vaccines (Influenza/Flu)" for a list of flu related resources.

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

Primary Care Incentive Payment (PCIP) Program

Per Section 5501(a) of the *Affordable Care Act*, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare's program payments to be paid to qualifying primary care physicians and non-physician practitioners for

services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found at **https://questions.cms.hhs.gov/app/answers/list/kw/pcip/sno/1/search/1/session/L3NpZC80dWhrOENJaw%3D%3D**. Alternatively, these FAQ items can be found by visiting **http://questions.CMS.hhs.gov/** and searching for "PCIP" or "Primary Care Incentive Payment."

MLN Connects™ Provider e-News (GEN)

MLN Connects™ Provider e-News for Thursday, March 13, 2014

http://go.usa.gov/K83W

MLN Connects™ National Provider Calls

- PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 - Last Chance to Register
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Last Chance to Register
- Did You Miss These MLN Connects™ Calls?

CMS Events

- Road to 10: ICD-10 Training Webinar Series
- ICD-10 Coordination and Maintenance Committee Meeting
- Volunteers Sought for ICD-10 End-to-End Testing: July 21-25

Announcements

- Medicare Provides Coverage for Certain Colorectal Cancer Screenings
- Part D Payment for Drugs for Beneficiaries Enrolled in Hospice: Final 2014 Guidance
- HQRP FY 2015 Reporting Cycle Data: Deadline April 1
- Submit Suggestions for Advanced Diagnostic Imaging Program
- EHR Incentive Programs: Medicare EPs Must Attest by March 31 to Receive 2013 Incentive
- Eligible Hospitals: Take Action by April 1 to Avoid 2015 EHR Incentive Program Payment Adjustment
- Learn About Upcoming PQRS Milestones this March
- Submit Your PQRS Quality Measures through the EHR Reporting Method

Claims, Pricers, and Codes

- Home Health Claims Incorrectly Paid with Reason Code V8030
- Updates to IRIS Software

MLN Educational Products

- "International Classification of Diseases, Tenth Revision (ICD-10) Limited End-to-End Testing with Submitters" MLN Matters® Article - Released
- "Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing" MLN Matters® Article - Released
- "Advance Beneficiary Notice of Noncoverage" Booklet - Revised
- "Hospital Outpatient Prospective Payment System" Fact Sheet - Revised
- "Clinical Laboratory Fee Schedule" Fact Sheet - Revised
- "Resources for Medicare Beneficiaries" Fact Sheet - Reminder
- "Complying With Medicare Signature Requirements" - Electronic Publication
- Submit Feedback on MLN Educational Products

MLN Connects™ Provider e-News for Thursday, March 20, 2014

http://go.usa.gov/KEym

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2015 - Registration Now Open
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Registration Opening Soon

CMS Events

- Volunteers Sought for ICD-10 End-to-End Testing: July 21-25

Announcements

- The Flu Season Is Not Over: It's Not Too Late to Get a Flu Vaccine
- 12 Days Remaining for Hospice Providers to Submit FY 2015 Reporting Cycle HQRP data
- Medicare EHR Incentive Program: Eligible Professionals Must Attest by March 31 to Receive 2013 Incentive

Claims, Pricers, and Codes

- Medicare Only Accepting Revised CMS 1500 Claim Form (02/12) Starting April 1
- Part A Provider Coordination of Benefits Error Code 000000

MLN Educational Products

- "Screening and Diagnostic Mammography" Booklet - Revised
- "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" Booklet - Revised

MLN Connects™ Provider e-News for Thursday, March 27, 2014

http://www.qrs.ly/i93y6u5

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2015 - Register Now
- How to Register for the PQRS Group Practice Reporting Option in 2014 - Registration Now Open
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Registration Now Open

CMS Events

- Hospice Item Set Data Collection Training Video Now Available

Announcements

- Medicare Care Choices Model Launched: Hospice Organizations Can Apply Through June 19
- ESRD QIP Website Improvements: New Resources for Providers
- 5 Days Remaining for Hospice Providers to Submit FY 2015 Reporting Cycle HQRP Data
- Submit Suggestions for Advanced Diagnostic Imaging Program
- EHR Incentive Program: Medicare EPs Must Attest by March 31 to Receive 2013 Incentive
- EHR Incentive Program: Medicare Eligible Hospitals Must Take Action by April 1 to Avoid 2015 Payment Adjustment
- EHR Incentive Program: Important Payment Adjustment Information for Medicare Eligible Professionals

MLN Educational Products

- Spring 2014 Version of The Medicare Learning Network® (MLN) Catalog - Now Available
- "Psychiatry and Psychotherapy Services" MLN Matters® Article - Re-Issued
- "Intensive Behavioral Therapy (IBT)" Booklet - Revised
- "Communicating With Your Medicare Patients" Fact Sheet - Revised

MLN Connects™ Provider e-News for Thursday, April 03, 2014

http://go.usa.gov/KJRh

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2015 - Last Chance to Register
- How to Register for the PQRS Group Practice Reporting Option in 2014 - Last Chance to Register
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes - Registration Now Open
- New MLN Connects™ National Provider Call Transcripts and Audio Recordings

Announcements

- Hospital Outpatient Supervision Level Designations: April 30 Deadline for Comments
- Physicians and Teaching Hospitals Do Not Need to Take Action Now in Open Payments
- PV-PQRS Registration System is Now Open
- 2-Midnight Rule: Provider Resources
- Submit Your 2014 PQRS Quality Measures through the Registry Reporting Method
- New Security Risk Assessment Tool Helps Providers Ensure HIPAA Compliance
- CMS Posts 2014 Eligible Hospital Electronic Clinical Quality Measure Annual Update

Claims, Pricers, and Codes

- Appeals for Cancelled Claims Related to Medicare Beneficiaries Classified as "Unlawfully Present" in the U.S.
- Mandatory Payment Reduction of 2% Continues through March 31, 2015, for the Medicare FFS Program - "Sequestration"
- Adjustment of Community Mental Health Center Claims for Telehealth Originating Facility Fees
- Incorrect Overpayments and Denials for Some New Patient Visit Claims

MLN Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 3]" Educational Tool- Released
- "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Educational Tool - Revised
- "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Educational Tool - Revised
- "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet - Reminder
- New MLN Provider Compliance Fast Fact
- MLN Product Available in Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, April 10, 2014

http://go.usa.gov/kgMH

MLN Connects™ National Provider Calls

- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Last Chance to Register
- Medicare Shared Savings Program ACO Application Process - Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now

Announcements

- Medicare Coverage Includes Screening and Counseling for Alcohol Misuse
- Historic Release of Data Gives Consumers Unprecedented Transparency on the Medical Services Physicians Provide and How Much They are Paid
- Participation Rises in Medicare PQRS and eRx Incentive Program
- Probe and Educate Clarifications: Timeframes for Additional Documentation Requests and Education

- EHR Incentive Programs: New Meaningful Use Calculator Helps Providers Attest to Stage 2
- Review New and Updated FAQs for the EHR Incentive Programs

Claims, Pricers, and Codes

- CMS Releases Modifications to HCPCS Code Set
- SNFs and Changes in Part B Payment Methodology for Certain DME

MLN Educational Products

- "Updating Beneficiary Information with the Benefits Coordination & Recovery Center (formerly known as the Coordination of Benefits Contractor)" MLN Matters® Article - Released
- "Basic Medicare Information for Providers and Suppliers" Guide - Revised
- "Mental Health Services" Booklet - Revised
- New MLN Educational Web Guides Fast Fact

MLN Connects™ Provider e-News for Thursday, April 17, 2014

http://go.usa.gov/kkfk

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO Application Process - Last Chance to Register
- Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing - Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now

CMS Events

- Special Open Door Forum: Suggested Electronic Clinical Template for Home Health

Announcements

- Prevention is Power: Taking Action for Health Equity
- CMS Proposes Adoption of Updated Life Safety Code
- Comprehensive ESRD Care Model
- HQRP Announces Call for Technical Expert Panel
- HQRP: Final Hospice Item Set Version and Data Specifications Available
- Review Your 2013 PQRS Interim Claims Feedback Data
- Eligible Professionals Must Start Medicare EHR Participation in 2014 to Earn Incentives
- Eligible Hospitals: Review Changes in Stage 1 Meaningful Use Criteria for EHR Incentive Program
- EHR Incentive Programs: Learn More about the Batch Reporting Option for 2014
- New EHR Incentive Programs Tipsheet for Eligible Professionals Practicing in Multiple Locations
- Learn More About eHealth with New Resources from CMS eHealth University

Claims, Pricers, and Codes

- PC Print Version 4.3.0 Incompatible with Microsoft XP
- SNF Consolidated Billing: Exclusion of HCPCS Code G0463 for Certain Outpatient Hospital Clinic Visits
- Hold on CAH Claims for Non-Patient Specimen Analysis
- Hold on Some Part B Claims Following April Inpatient Payment Policy Update

MLN Educational Products

- "Certifying Physicians and the Phase 2 Ordering and Referring Denial Edits for Home Health Agencies (HHAs)" MLN Matters® Article - Released
- "Implementation of Fingerprint-Based Background Checks" MLN Matters® Article - Released
- "Medicaid Program Integrity: What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs?" Fact Sheet - Released
- "CMS Website Wheel" Educational Tool - Revised

- MLN Products Available in Electronic Publication Format
- Pilot Testers Needed

MLN Connects™ Provider e-News for Thursday, April 24, 2014

http://go.usa.gov/kPsH

MLN Connects™ National Provider Calls

- Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals - Registration Opening Soon
- New MLN Connects™ National Provider Call Transcripts and Audio Recordings

CMS Events

- Webinar for Comparative Billing Report on Diabetic Testing Supplies

Announcements

- Data from Inpatient Psychiatric Facilities Increase Transparency for Consumers Evaluating Facilities
- CMS National Dry Run of the Standardized Readmission Ratio for Dialysis Facilities Ends May 2
- CMS to Begin Accepting Suggestions for Potential PQRS Measures in May
- Hospice Item Set Manual: Change Table for V1.00.0 to V1.01 Now Available
- CMS to Release a Comparative Billing Report on Diabetic Testing Supplies in April
- Learn About the Special EHR Reporting Periods for Eligible Professionals in 2014
- EHR Incentive Program: Hardship Exception Applications due July 1 for Eligible Professionals
- EHR Incentive Programs: Eligible Professionals Should Review Changes in Stage 1 Meaningful Use Criteria

Claims, Pricers, and Codes

- April 2014 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products

- "Provider Compliance Tips for Computed Tomography (CT Scans)" Fact Sheet - Released
- "Part C Appeals: Organization Determinations, Appeals & Grievances" Web-Based Training Course - Released
- "Part D Coverage Determinations, Appeals & Grievances" Web-Based Training Course - Released
- "Duplicate Claims - Outpatient" Podcast - Released
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet - Revised
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, May 01, 2014

http://go.usa.gov/k7hh

MLN Connects™ National Provider Calls

- Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Review of the New Medicare PPS for Federally Qualified Health Centers - Registration Now Open
- Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals - Registration Now Open
- New MLN Connects™ National Provider Call Transcript and Audio Recording

CMS Events

- Inpatient Rehabilitation Facility Quality Reporting Program Training

Announcements

- CMS Finalizes a Medicare Prospective Payment System for Federally Qualified Health Centers
- Interactive Tool Allows Easier Access to Physician Data
- Notices of Intent to Apply for the Medicare Shared Savings Program 2015 Program Start Date Due by May 30
- Ordering and Referring Denial Edits Will Apply to Certifying Physicians for HHAs Beginning July 7
- New DOTPA Reports Available
- CMS is Accepting Suggestions for PQRS Measures
- New Fact Sheet Available on How to Avoid the 2016 PQRS Payment Adjustment
- PQRS Participants: New Email Address for QualityNet Help Desk

Claims, Pricers, and Codes

- Preventive Services Payable to RHCs and FQHCs

MLN Educational Products

- "HIPAA EDI Standards" Web-Based Training Course - Revised
- MLN Products Available in Electronic Publication Format
- New MLN Provider Compliance Fast Fact
- New MLN Educational Web Guides Fast Fact

MLN Connects™ Provider e-News for Thursday, May 08, 2014

http://go.usa.gov/kSd5

MLN Connects™ National Provider Calls

- Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Review of the New Medicare PPS for Federally Qualified Health Centers - Register Now
- Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals - Register Now
- New MLN Connects™ National Provider Call Transcript and Audio Recording

CMS Events

- Recorded Hospice Item Set Technical Training Modules Available

Announcements

- CMS Proposes Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit
- Proposed FY 2015 Payment and Policy Changes for Medicare Skilled Nursing Facilities
- Proposed FY 2015 Medicare Payment and Policy Changes for Inpatient Psychiatric Facilities
- Proposed FY 2015 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities
- Empowering Women's Health
- Open Payments: Physician and Teaching Hospital Registration Begins June 1
- New Feature: Online Unlock Account Feature for PECOS, NPPES, and EHR
- Physician Self-Referral Law: Expansion Exception Request
- EHR Incentive Program Eligible Professionals: Hardship Exception Applications due July 1
- Register for the Group Practice Reporting Option for 2014 PQRS Participation by September 30

Claims, Pricers, and Codes

- CY 2014 Home Health PPS PC Pricer Available
- Adjustments to CMHC Claims Incorrectly Processed

- Adjustments to Correct Home Health Claim Payments
- Mass Adjustments to Inpatient Psychiatric Facility Claims with Teaching Adjustment Amounts Not Displaying Correctly

MLN Educational Products

- "Medicare Shared Savings Program and Rural Providers" Fact Sheet - Revised
- "Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program" Fact Sheet - Revised
- "Advance Payment Accountable Care Organization" Fact Sheet - Revised
- "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements" Fact Sheet - Revised
- "Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program" Fact Sheet - Revised
- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet - Revised
- "The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet - Revised
- "Accountable Care Organizations: What Providers Need to Know" Fact Sheet - Revised
- "Improving Quality of Care for Medicare Patients: Accountable Care Organizations" Fact Sheet - Revised
- "Medical Privacy of Protected Health Information" Fact Sheet - Reminder
- MLN Publications Now Available in Hard Copy Format

MLN Connects™ Provider e-News for Thursday, May 15, 2014

http://go.usa.gov/843H

MLN Connects™ National Provider Calls

- Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing - Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes - Last Chance to Register
- Review of the New Medicare PPS for Federally Qualified Health Centers - Last Chance to Register
- Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals - Register Now
- More ICD-10 Coding Basics - Registration Now Open

CMS Events

- Special Open Door Forum: Suggested Electronic Clinical Template for Home Health
- Webinar for Comparative Billing Report on Ambulance: Ground Transportation
- HART User Tool Training Modules Available for Hospice Quality Reporting Program

Announcements

- Reforms of Regulatory Requirements to Save Health Care Providers $660 Million Annually
- New HHS Data Show Quality Improvements Saved 15,000 lives and $4 Billion in Health Spending
- Quality Improvement Organization Program Advisory
- Notices of Intent to Apply for the Medicare Shared Savings Program 2015 Program Start Date Due by May 30
- New PEPPER Release for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- CMS to Release a Comparative Billing Report on Ambulance: Ground Transportation in May
- Physician Self-Referral Law: Expansion Exception Request

Claims, Pricers, and Codes

- Acute Inpatient PPS FY 2014.6 Pricer Software Release Available
- Hold and Adjustments to Method II CAH Claims that Include Services for a Surgical Assistant
- Mass Adjustments to Inpatient Psychiatric Facility Claims with Teaching Adjustment Amounts Not Displaying Correctly

MLN Educational Products

- "Screening and Diagnostic Mammography" Booklet - Revised

- "Telehealth Services" Fact Sheet - Revised
- "Ambulatory Surgical Center Fee Schedule" Fact Sheet - Revised
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, May 22, 2014

http://go.cms.gov/1jVHzTn

MLN Connects™ National Provider Calls

- Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals - Last Chance to Register
- More ICD-10 Coding Basics - Register Now
- Medicare Shared Savings Program ACO: Application Review - Registration Now Open
- Open Payments (the *Sunshine Act*): Updates for Physicians and Teaching Hospitals - Registration Opening Soon
- PQRS: 2014 Qualified Clinical Data Registry - Registration Now Open

Announcements

- "Mind Your Health" - Recognizing the Importance of Mental Health
- "Generations of Strength" - Preventing Osteoporosis Among Medicare Beneficiaries
- CMS Rule to Help Providers Make Use of Certified EHR Technology
- User ID Reminder for 2015 Medicare Shared Savings Program Applicants
- Am I Eligible to Order and Refer Medicare Items and Services?
- Registration for Hospice User IDs Began May 19
- Medicare GME Affiliation Agreements: July 1 Deadline
- CMS is Accepting Suggestions for PQRS Measures
- Learn About the Special EHR Reporting Periods for Eligible Professionals in 2014
- Medicare EHR Incentive Program: Review Steps for Submitting Stage 2 Meaningful Use Data
- New Resources Explain How to Report Once for Multiple Medicare Quality Reporting Programs

Claims, Pricers, and Codes

- 2015 ICD-10-CM, ICD-10-PCS, and ICD-9-CM Files Available
- Partial Code Freeze for ICD-9-CM and ICD-10 Extended
- Demonstration Allows Public Input on Requests to Discontinue Level II HCPCS Codes
- FY 2014 Inpatient PPS PC Pricer: New Provider Data
- Revision to the Replacement of Home Oxygen Services in the Event that Supplier Exits the Medicare Oxygen Business

MLN Educational Products

- New MLN Educational Web Guides Fast Fact
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects™ Provider e-News for Thursday, May 29, 2014

http://go.usa.gov/8PgC

MLN Connects™ National Provider Calls

- More ICD-10 Coding Basics - Last Chance to Register
- Medicare Shared Savings Program ACO: Application Review - Register Now
- Open Payments (the *Sunshine Act*): CMS Registration Overview - Registration Now Open
- PQRS: 2014 Qualified Clinical Data Registry - Register Now

Announcements

- Prior Authorization to Ensure Beneficiary Access and Help Reduce Improper Payments
- Application Deadlines for the 2015 Medicare Shared Savings Program
- Hospice Item Set Implementation Begins July 1
- Updated Information on Post-Acute Transfer Adjusted Cases in IPPS Proposed Rule
- Submit Your 2014 PQRS Quality Measures through the GPRO Web Interface Method

Claims, Pricers, and Codes

- 2015 GEMs and Reimbursement Mappings for ICD-10 Now Available

MLN Educational Products

- "Proper Use of Modifier 59" MLN Matters® Article - Released
- "Medical Privacy of Protected Health Information" Fact Sheet - Reminder
- New MLN Provider Compliance Fast Fact
- Electronic Publications Now Available

MLN Connects™ Provider e-News for Thursday, June 05, 2014

http://go.cms.gov/S8OnGR

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO: Application Review - Last Chance to Register
- Open Payments (the *Sunshine Act*): CMS Registration Overview - Last Chance to Register
- PQRS: 2014 Qualified Clinical Data Registry - Register Now
- New Medicare PPS for Federally Qualified Health Centers: Operational Requirements - Registration Now Open
- New MLN Connects™ National Provider Call Transcripts and Audio Recordings

CMS Events

- PERM Cycle 3 Provider Education Webinar/Conference Call Sessions
- ICD-10 Documentation and Coding Concepts Webcast: Orthopedics

Announcements

- Successful Results from CMS ICD-10 Acknowledgement Testing Week
- Men's Health is not Just a Man's Issue
- HHS Releases New Data and Tools to Increase Transparency on Hospital Utilization and Other Trends
- 2015 Medicare Shared Savings Program Application Now Available: Form CMS-20037 Due by June 9
- Hospices: Begin Collecting HIS Data July 1 to Avoid Reduction in FY 2016 Annual Payment Update
- CMS is Accepting Suggestions for PQRS Measures
- Medicare EHR Incentive Program: Eligible Professionals Must Submit Hardship Exception Applications by July 1
- CMS Posts 2014 Eligible Professional Electronic Clinical Quality Measure Update

Claims, Pricers, and Codes

- Updated ESRD PPS Consolidated Billing List Now Available
- 2015 ICD-10-CM, ICD-10-PCS, and ICD-9-CM Files Available

MLN Educational Products

- "What Is Medicare?" Video - Released
- "Proper Use of Modifier 59" MLN Matters® Article - Revised
- "Medicare-Covered Part A and Part B Services Furnished Outside the United States" Fact Sheet - Revised
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet - Revised
- "Quick Reference Information: Preventive Services" Educational Tool - Reminder

- "Quick Reference Information: Medicare Immunization Billing" Educational Tool - Reminder
- MLN Products Available In Electronic Publication Format

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

Billing Reminder: Modifier Usage for Urological Supplies - Revised - DME MAC Joint Publication (SPE)

The Urological Supplies Local Coverage Determination (LCD) provides the use of modifiers with each submitted Healthcare Common Procedural Coding System (HCPCS) code. The use of the modifiers will indicate whether the applicable payment criteria are met (KX modifier), and provide information related to the coverage and/or liability (GA, GZ and GY modifiers) when the policy criteria are not met. This article reflects the appropriate use of each modifier to ensure correct use. Instructions for the GA and GZ modifiers were recently included in this LCD for proper consideration of usage (December 2013).

Proper selection of the correct G modifier requires an assessment of the possible cause for a denial. Some criteria are based upon statutory requirements. Failure to meet a statutory requirement justifies the use of the GY modifier. When Reasonable and Necessary (R&N) criteria are not met, either the GA or GZ modifier is appropriate based upon Advance Beneficiary Notice of Noncoverage (ABN) status.

Urological supplies are payable under the Prosthetic Device benefit (*Social Security Act* § 1861(s)(8)). Urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in the affected beneficiary within 3 months. These requirements are statutory benefit requirements. When a beneficiary does not meet these requirements, the GY modifier must be used.

Aside from the above statutory coverage criteria, the remaining payment requirements are classified as R&N requirements. Examples (not all-inclusive) include utilization limits, medical necessity criteria for sterile kits, correct coding, etc. For those situations where R&N criteria are not met, either the GA or GZ modifier would be the appropriate choice depending upon ABN status.

Use of these modifiers is mandatory. Claim lines billed without a KX, GA, GY or GZ modifier will be rejected as missing information.

KX - Requirements specified in the medical policy have been met
The KX modifier must be appended to a catheter code, an external urinary collection device or a supply item when all of the statutory and R&N requirements have been met. Suppliers are not required to secure all of the required documentation prior to claim submission, however, appending the KX modifier to each of the urological codes billed serves as an attestation by the supplier that the requirements for its use have been met.

GA - Waiver of liability (expected to be denied as not reasonable and necessary, ABN on file)
When a Medicare claim denial is expected because an item or service does not meet the R&N criteria, the supplier must issue an ABN to the beneficiary before furnishing the item or service. When the beneficiary accepts financial responsibility and signs a valid ABN, the supplier submits the claim to Medicare appending modifier GA to each corresponding HCPCS code. Modifier GA indicates that the supplier has a waiver of liability statement on file. Modifier GA must not be submitted if a valid ABN is not issued. Claims submitted with the GA modifier will receive a medical necessity denial holding the beneficiary liable.

GZ - Item or service not reasonable and necessary (expected to be denied as not reasonable and necessary, no ABN on file)
When a Medicare claim denial is expected because an item or service does not meet the R&N criteria, the supplier is expected to issue an ABN to the beneficiary. If the supplier chooses to accept liability for the expected denial, the supplier must append the GZ modifier to each corresponding HCPCS code. Modifier GZ indicates that the supplier does not have a waiver of liability statement on file. Claims submitted with the GZ modifier will receive a medical necessity denial holding the supplier liable.

GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
The GY modifier indicates that an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. For urological supplies, the prosthetic benefit requires that the beneficiary must have a permanent impairment of urination. In cases where the statutory criteria are not met, suppliers are required to code their claims for urological supplies with the GY modifier. Claims submitted with the GY modifier will be denied as statutorily noncovered holding the beneficiary liable for the excluded services. Refer to the Urological Supplies LCD and related Policy Article for additional information about the payment rules, coding and documentation requirements.

Changes to Local Coverage Determinations - ICD-10 Updates - Joint DME MAC Publication (GEN)

The DME MACs are providing notice that all ICD-10 LCDs and associated ICD-10 articles will be updated in the Medicare Coverage Database no later than 04/10/14. For LCDs and related Policy Articles that translate ICD-9 codes to the appropriate ICD-10 code, there is no requirement for the public comment process.

The following LCDs and related Policy Articles have ICD-9 to ICD-10 translations and will receive new LCD/Article ID numbers:

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- Automatic External Defibrillators
- External Breast Prostheses
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Immunosuppressive Drugs - Policy Article
- Intravenous Immune Globulin - Policy Article
- Knee Orthoses
- Mechanical In-exsufflation Devices
- Nebulizers
- Oral Anticancer Drugs - Policy Article
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) - Policy Article
- Oral Appliances for Obstructive Sleep Apnea
- Orthopedic Footwear
- Osteogenesis Stimulators
- Ostomy Supplies - Policy Article
- Oxygen and Oxygen Equipment
- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea
- Pressure Reducing Support Surfaces - Group 2
- Pressure Reducing Support Surfaces - Group 3
- Refractive Lenses
- Suction Pumps
- Therapeutic Shoes for Persons with Diabetes - Policy Article
- Tracheostomy Care Supplies - Policy Article
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Urological Supplies
- Wheelchair Seating
- VED - DRAFT

All LCDs and related Policy Articles will receive a new LCD/Article ID number. The Centers for Medicare & Medicaid (CMS) has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, 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. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be sent through the public Comment and notice process.

Correct Coding - Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Revised - Joint DME MAC Publication (O&P)

As part of the 2014 HCPCS update codes were created describing certain off-the-shelf (OTS) orthotics. Some of these codes parallel codes for custom fitted versions of the same items. Refer to the appropriate Local Coverage Determination (LCD) for a list of codes.

When providing these items suppliers must:

- Provide the product that is specified by the ordering physician, i.e. (1) type of orthosis and (2) method of fitting (OTS or custom fitted)
- Be sure that the medical record justifies the need for the type of product and method of fitting
- Be sure only to use the code that accurately reflects both the type of orthosis and the appropriate level of fitting
- Have detailed documentation that justifies the code selected for custom fitted versus OTS codes)

The following definitions will be used for correct coding of these items.

Off-the-shelf (OTS) orthotics are:

- Items that are prefabricated
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted
- OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit an individual
- This fitting does not require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary

The term "minimal self-adjustment" is defined at 42 CFR §414.402 as an adjustment the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

Fabrication of an orthosis using CAD/CAM or similar technology without the creation of a positive model with minimal self-adjustment at delivery is considered as OTS.

Custom fitted orthotics are:

- Devices that are prefabricated
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as custom fitted if the final fitting upon delivery to the patient requires substantial modification requiring expertise as described in this section.

A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

Kits are:

- A collection of components, materials and parts that require further assembly before delivery of the final product
- The elements of a kit may be packaged and complete from a single source or may be an assemblage of separate components from multiple sources by the supplier

A summary classification algorithm is included at the end of this document to assist in determinations about the type of product and correct code selection.

Refer to the Contractor *Supplier Manual*, applicable Local Coverage Determination and related Policy Article for additional information about other coverage, coding and documentation requirements.

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

Classification Algorithm - Overview of Criteria

Determining Proper Coding of Prefabricated Orthotics

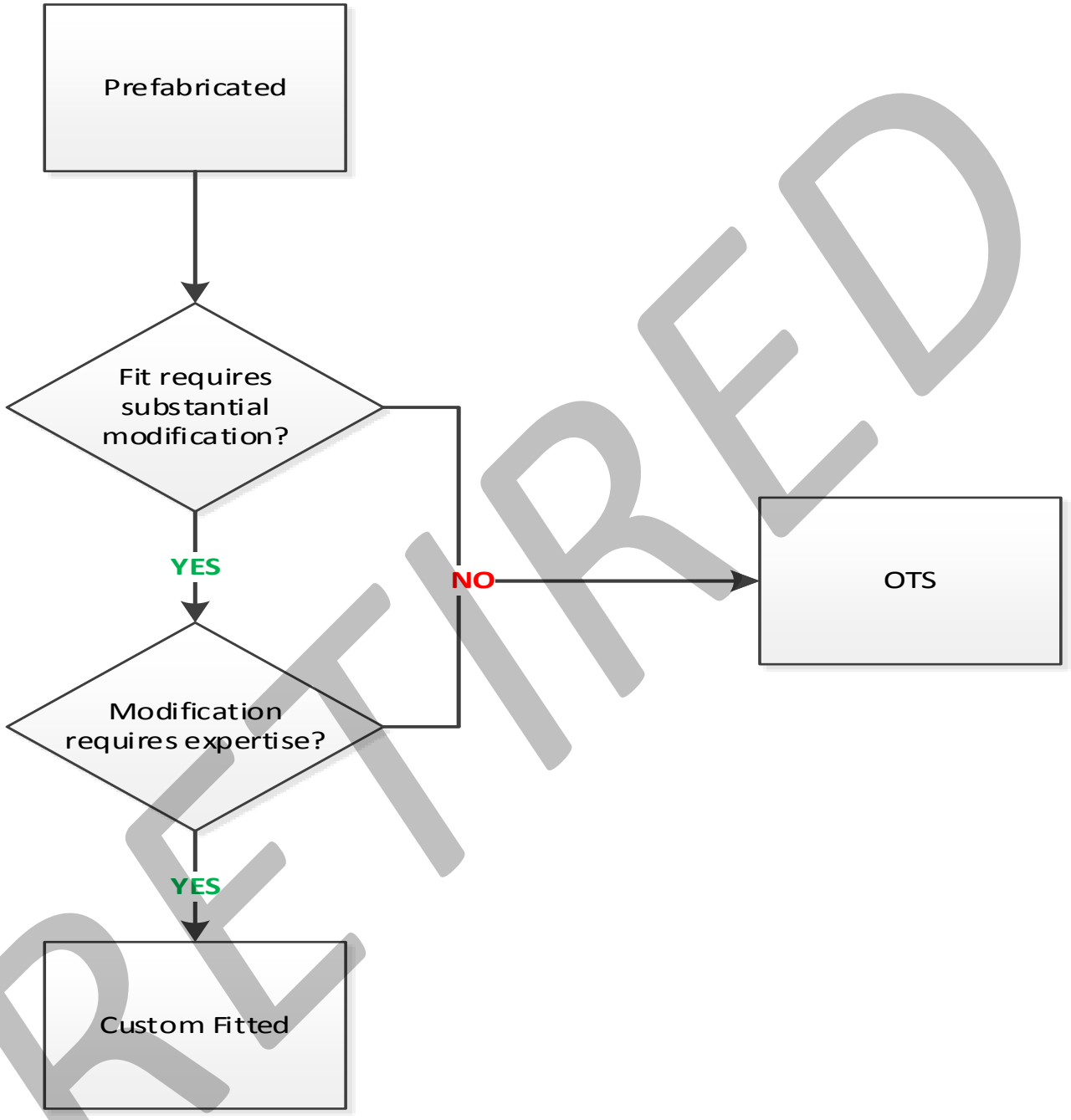
The following question and answer relates to whether a prefabricated orthotic is properly billed using a code for a custom fitted orthotic versus one furnished off-the-shelf and does not address medical necessity for the item. The descriptors for the HCPCS codes for custom fitted orthotics include the following nomenclature:

- Off-the-shelf (OTS) - Prefabricated item that requires minimal self-adjustment such as being trimmed, bent, molded, assembled, or otherwise adjusted to fit the beneficiary. Minimal self-adjustment does not require the expertise of a certified orthotist or an individual with equivalent expertise.
- Custom fitted - Prefabricated item that requires substantial modification e.g., has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by certified orthotist or an individual with equivalent expertise.

Question: Is the prefabricated orthotic furnished with custom fitting that is and can only be provided by an individual with expertise or furnished off-the-shelf (OTS)?

Answer: Classification depends on (1) what must be done at final fitting and (2) who must do it. Expertise of a qualified practitioner and substantial modification at the time of delivery qualify the items for classification as custom fitted. Fail either one of these criteria and the item is classified as off-the-shelf.

How to Decide What Code Type for Prefabricated Orthotic



Correct Coding - Lithium Batteries (GEN)

The DME MACs have recently noted confusion on the part of DMEPOS suppliers regarding the proper billing of lithium batteries. There are two types of lithium batteries - Lithium batteries and Lithium Ion batteries. Lithium ion batteries are commonly used in consumer electronic devices and are rechargeable. Standard lithium batteries are disposable, non-rechargeable batteries. Suppliers must take care to properly distinguish between lithium ion and lithium batteries when billing claims to Medicare.

The following HCPCS codes are used to correctly code lithium batteries:

A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4601	Lithium ion battery for non-prosthetic use, replacement
E2397	Power wheelchair accessory, lithium-based battery, each
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
L7367	Lithium ion battery, replacement

Code A4235 describes a lithium battery, not a lithium ion battery. This code is used to bill lithium batteries for glucose monitors, regardless of the voltage.

Codes K0604 and K0605 describe lithium batteries commonly used in external insulin infusion pumps. Note that each code has an associated voltage. Claims for lithium batteries for external insulin infusion pumps (E0784) that do not use a voltage described by either code K0604 and K0605 must be billed using code A9999.

Code A4601 describes a lithium ion battery, not a lithium battery. Suppliers billing code A4601 must include, in the claim narrative field:

- The type of base DME item for which A4601 is being used; and,
- The manufacturer, model number, and manufacturer's suggested retail price (MSRP) for the battery.

Codes E2397 and L7367 describe lithium ion batteries for power wheelchairs and prosthetics, respectively.

Refer to the Contractor *Supplier Manual*, applicable Local Coverage Determination and related Policy Article for additional information about other coverage, coding and documentation requirements.

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

Correct Coding - Billing of Powered L-Coded Items - DME MAC Joint Publication (O&P)

There are an increasing number of L-coded items, both orthotic and prosthetic components, which are electrically powered. Errors associated with correct coding these items have been identified in recent reviews.

Billing Of Batteries and Chargers Concurrently With a Powered Base Item

Powered base items are those that contain the power source (battery). At the time that a base item is billed, all necessary batteries and/or battery chargers are considered as included in the payment for the powered base item. There is no separate payment for batteries (L7360, L7364, L7367, and L8505) and/or battery chargers (L7362, l7366, L7368) billed concurrently with a powered base item.

Payment for items listed in Column II are included in the payment for each Column I code. Claims for Column II items billed with the provision of a Column I item will be denied as unbundling.

Column I	Column II
Base codes with battery, charger and/or power included L2005 L3904 L5781 L5782 L5856 L5857 L5858 L5859 L5973 L6025 L6920-L6975 L8500 L8510	Batteries L7360 L7364 L7367 L8505 Chargers L7362 L7366 L7368

Billing of Powered Add-Ons

Many powered base items are used concurrently with add-on items that derive power from the power source contained in the base item. At the time that an add-on to a base item is billed, all necessary batteries and/or battery chargers are considered as included in the payment for the powered base item. There is no separate payment for batteries (L7360, L7364, L7367, and L8505) and/or battery chargers (L7362, l7366, L7368) billed concurrently with a powered base item or associated add-ons.

Payment for items listed in Column III are included in the payment for each Column II code. Claims for Column III items billed with the provision of a Column I item will be denied as unbundling.

Column I	Column II	Column III
Add-on codes used with base codes L5969 L6621 L6638 L6646 L6648 L6880-L6885 L7007-L7261	Base codes with battery, charger and/or power included L2005 L3904 L5781 L5782 L5856 L5857 L5858 L5859 L5973 L6025 L6920-L6975 L8500 L8510	Batteries L7360 L7364 L7367 L8505 Chargers L7362 L7366 L7368

These correct coding tables will be effective for claims with DOS on or after 05/01/2014.

Refer to the applicable Local Coverage Determination, related Policy Article and *Supplier Manual* for additional information.

Codes addressed in this article

HCPCS	NARRATIVE DESCRIPTION
L2005	KNEE ANKLE FOOT ORTHOSIS, ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED
L3904	WRIST HAND FINGER ORTHOSIS, EXTERNAL POWERED, ELECTRIC, CUSTOM-FABRICATED
L5781	ADDITION TO LOWER LIMB PROSTHESIS, VACUUM PUMP, RESIDUAL LIMB VOLUME MANAGEMENT AND MOISTURE EVACUATION SYSTEM
L5782	ADDITION TO LOWER LIMB PROSTHESIS, VACUUM PUMP, RESIDUAL LIMB VOLUME MANAGEMENT AND MOISTURE EVACUATION SYSTEM, HEAVY DUTY
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSORCONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
L5859	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, POWERED AND PROGRAMMABLE FLEXION/EXTENSION ASSIST CONTROL, INCLUDES ANY TYPE MOTOR(S)
L5969	ADDITION, ENDOSKELETAL ANKLE-FOOT OR ANKLE SYSTEM, POWER ASSIST, INCLUDES ANY TYPE MOTOR(S)
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE
L6025	ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM
L6621	UPPER EXTREMITY PROSTHESIS ADDITION, FLEXION/EXTENSION WRIST WITH OR WITHOUT FRICTION, FOR USE WITH EXTERNAL POWERED TERMINAL DEVICE
L6638	EXTREMITY ADDITION TO PROSTHESIS, ELECTRIC LOCKING FEATURE, ONLY FOR USE WITH MANUALLY POWERED ELBOW
L6646	UPPER EXTREMITY ADDITION, SHOULDER JOINT, MULTIPOSITIONAL LOCKING, FLEXION, ADJUSTABLE ABDUCTION FRICTION CONTROL, FOR USE WITH BODY POWERED OR EXTERNAL POWERED SYSTEM
L6648	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, EXTERNAL POWERED ACTUATOR
L6880	ELECTRIC HAND, SWITCH OR MYOLELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)
L6881	AUTOMATIC GRASP FEATURE, ADDITION TO UPPER LIMB ELECTRIC PROSTHETIC TERMINAL DEVICE
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB PROSTHETIC TERMINAL DEVICE
L6883	REPLACEMENT SOCKET, BELOW ELBOW/WRIST DISARTICULATION, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER

HCPCS	NARRATIVE DESCRIPTION
L6884	REPLACEMENT SOCKET, ABOVE ELBOW/ELBOW DISARTICULATION, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER
L6885	REPLACEMENT SOCKET, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER
L6920	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL, SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6925	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6930	BELOW ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6935	BELOW ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6940	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6945	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6950	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6955	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6960	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6965	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6970	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6975	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT

HCPCS	NARRATIVE DESCRIPTION
L7008	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, PEDIATRIC
L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT
L7010	ELECTRONIC HAND, OTTO BOCK, STEEPER OR EQUAL, SWITCH CONTROLLED
L7015	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7020	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, SWITCH CONTROLLED
L7025	ELECTRONIC HAND, OTTO BOCK OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7030	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7035	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED
L7045	ELECTRONIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, PEDIATRIC
L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED
L7180	ELECTRONIC ELBOW, MICROPROCESSOR SEQUENTIAL CONTROL OF ELBOW AND TERMINAL DEVICE
L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OF ELBOW AND TERMINAL DEVICE
L7185	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7186	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7190	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7191	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7260	ELECTRONIC WRIST ROTATOR, OTTO BOCK OR EQUAL
L7261	ELECTRONIC WRIST ROTATOR, FOR UTAH ARM
L7360	SIX VOLT BATTERY, EACH
L7362	BATTERY CHARGER, SIX VOLT, EACH
L7364	TWELVE VOLT BATTERY, EACH
L7366	BATTERY CHARGER, TWELVE VOLT, EACH
L7367	LITHIUM ION BATTERY, REPLACEMENT
L7368	LITHIUM ION BATTERY CHARGER, REPLACEMENT ONLY
L8500	ARTIFICIAL LARYNX, ANY TYPE
L8505	ARTIFICIAL LARYNX REPLACEMENT BATTERY / ACCESSORY, ANY TYPE
L8510	VOICE AMPLIFIER

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 and Coverage of Ventilators - Joint DME MAC Publication (SPE)

Ventilator technology has evolved to the point where it is possible to have a single device capable of operating in numerous modes, from basic continuous positive pressure (CPAP and bi-level PAP) to traditional pressure and volume ventilator modes. This creates the possibility that one piece of equipment may be able to replace numerous and different pieces of equipment. Equipment with multifunction capability creates the possibility of errors in claims submitted for these items. This article will discuss the application of Medicare proper coding and payment rules for ventilators.

CODING

Items classified as ventilators must be billed using the HCPCS codes describing ventilators. The HCPCS codes for ventilators are:

- E0450 - VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)
- E0460 - NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY
- E0461 - VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)
- E0463 - PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G. TRACHEOSTOMY TUBE)
- E0464 - PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)

NOTE: Ventilators must not be billed using codes for CPAP (E0601) or bi-level PAP (E0470, E0471, E0472). Using the CPAP or bi-level PAP HCPCS codes to bill a ventilator is incorrect coding, even if the ventilator is only being used in CPAP or bi-level mode (see below). Claims for ventilators used in CPAP or bi-level PAP scenarios will be denied as incorrect coding.

COVERAGE

Items may only be covered based upon the applicable reasonable and necessary (R&N) criteria and based upon the classification assigned to the device. The Centers for Medicare & Medicaid Services (CMS) *National Coverage Determinations Manual* (Internet-Only Manual, Publ. 100-3) in Chapter 1, Part 4, Section 280.1 stipulates that ventilators are covered for the following conditions:

> [N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. These disease groups may appear to overlap conditions described in the Respiratory Assist Devices LCD but they are not overlapping. Choice of an appropriate device i.e., a ventilator vs. a bi-level PAP device is made based upon the severity of the condition. CMS distinguished the use of respiratory product types in a National Coverage Analysis Decision Memo (CAG-00052N) in June 2001:

> RADs [bi-level PAP devices] provide noninvasive positive pressure respiratory assistance (NPPRA). Note that some studies in the literature refer to this as noninvasive positive pressure ventilation (NPPV).
>
> NPPRA is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access. It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is distinguished from the invasive ventilation administered via a securely intubated airway, in a patient for whom interruption or failure of respiratory support leads to death.

The conditions described in the Respiratory Assistance Devices (RAD) local coverage determination are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death. These policies describe clinical conditions that require intermittent and relatively short durations of respiratory support. Thus, a ventilator would not be eligible for reimbursement for any of the conditions described in the RAD LCD even though the ventilator equipment may have the capability of operating in a bi-level PAP (E0470, E0471, E0472) mode. Bi-level PAP devices (E0470, E0471) are considered as R&N in those clinical scenarios.

A ventilator would not be considered reasonable and necessary (R&N) for the treatment of obstructive sleep apnea, as described in the PAP LCD, even though the ventilator equipment may have the capability of operating in a CPAP (E0601) or bi-level PAP (E0470) mode.

Claims for ventilators used for the treatment of conditions described in the PAP or RAD LCDs will be denied as not reasonable and necessary.

UPGRADES

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. In some cases, CMS' policy that allows for billing of upgrade modifiers can be used when providing an item or service that is considered beyond what is medically necessary. This is NOT applicable to ventilators in the situations described above.

Although the use of a ventilator to treat any of the conditions contained in the PAP or RAD LCDs is considered "more than is medically necessary", the upgrade billing provisions may not be used to provide a ventilator for conditions described in the PAP or RAD LCDs. CPAP and bi-level PAP items are in the Capped-Rental payment category while ventilators are in the Frequent and Substantial Servicing payment category. Upgrade billing across different payment categories is not possible.

PRICING CATEGORY

Ventilators are classified in the Frequent and Substantial Servicing (FSS) payment category. FSS item are those for which there must be frequent and substantial servicing in order to avoid risk to the patient's health. CMS designates the items which fall into this payment group. The monthly rental payment for items in this pricing category is all-inclusive meaning there is no separate payment by Medicare for any options, accessories or supplies used with a ventilator. In addition, all necessary maintenance, servicing, repairs and replacement are also included in the monthly rental. Claims for these items and/or services will be denied as unbundling.

COVERAGE OF SECOND VENTILATOR

Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary - same/similar equipment.
Backup equipment must be distinguished from multiple medically necessary items which are defined as, identical or similar devices each of which meets a different medical need for the beneficiary. Although Medicare does not pay separately for backup equipment, Medicare will make a separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the beneficiary's medical needs.

The following are examples of situations in which a beneficiary would qualify for both a primary ventilator and a secondary ventilator:

- A beneficiary requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g. positive pressure ventilator with a nasal mask) during the rest of the day.

- A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without two pieces of equipment, the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

Refer to the PAP and RAD LCDs and related Policy Articles for additional information on coverage, coding and documentation of these items.

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

Medical Grade Honey as a Surgical Dressing Component - Request for Information - DME MAC Joint Publication (SPE)

Surgical Dressings are covered by the DME MACs when used on a qualifying wound. Medical grade honey has been a component in many dressings. Recently the DME MACs were called upon to evaluate the generally accepted medical uses of honey in wounds. As part of our evaluation, we are soliciting information from interested parties. We are requesting that interested parties provide relevant clinical evidence discussing the accepted uses of medical grade honey in wound care.

We make these determinations using an evidence-based medical standard in a review of the published clinical literature. The Medicare standard for clinical evidence is described in the *Program Integrity Manual* (Internet-Only Manual, Pub. 100-08, Chapter 13, §13.7.1):

> [S]hall be based on the strongest evidence available. The extent and quality of supporting evidence is key... The initial action in gathering evidence … shall always be a search of published scientific literature for any available evidence pertaining to the item or service in question. In order of preference:
>
> - Published authoritative evidence derived from definitive randomized clinical trials or other definitive studies, and
> - General acceptance by the medical community (standard of practice), as supported by sound medical evidence based on:
>   - Scientific data or research studies published in peer-reviewed medical journals;
>   - Consensus of expert medical opinion (i.e., recognized authorities in the field); or
>   - Medical opinion derived from consultations with medical associations or other health care experts.
>
> Acceptance by individual health care providers, or even a limited group of health care providers, normally does not indicate general acceptance by the medical community. Testimonials indicating such limited acceptance, and limited case studies distributed by sponsors with financial interest in the outcome, are not sufficient evidence of general acceptance by the medical community. The broad range of available evidence must be considered and its quality shall be evaluated before a conclusion is reached.

Interested parties choosing to provide information are encouraged to use this standard as well.

We request that all information be submitted electronically to: **NHICdmedraftlcdfeedback@hp.com**

Deadline for Submission of Information: **August 1, 2014**

MyoPro™ - Coding Reminder - Joint DME MAC Article (GEN)

The MyoPro™ (Myomo, Inc.) is an upper extremity device that incorporates muscle sensors and an electric motor to augment patient-initiated movement. According to the company's web site, the MyoPro is "designed to enable individuals to self-initiate and control movements of a partially paralyzed or weakened arm using their own muscle signals. When the user tries to bend their arm, sensors in the brace detect the weak muscle signal, which activates the motor to move the arm in the desired direction."

Upon evaluation of this product, the DME MACs and the PDAC have determined that:

- This item falls within the Durable Medical Equipment benefit category, not within the Braces benefit.
- This device must be coded as A9300 - EXERCISE EQUIPMENT

Exercise equipment is non-covered by Medicare. Claims for A9300 will be denied as non-covered (no Medicare benefit).

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.

April 2014 - Home Oxygen Initial Qualification Testing (OXY)

Dear Physician,

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when beneficiary meets all of the requirements set out in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) and related Policy Article (PA). This article reviews the blood oxygen testing requirements. Refer to the LCD and PA for information on additional payment criteria.

Timing of Physician Visit and Testing

For initial qualification testing scenarios, the beneficiary must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification. In addition, the qualification testing must be performed within the 30 days before the initial date of service.

As described earlier, for oxygen initially prescribed at the time of hospital discharge, testing must be performed within the 2 days prior to discharge. This 2-day prior to discharge rule does not apply to discharges from nursing facilities.

Qualifying Test Results

The results of a blood oxygen study that has been ordered and evaluated by the attending physician are used as one of the criteria for determining Medicare reimbursement.

Medicare classifies qualification results into three groups, regardless the test methodology used. The following table summarizes the qualifying results for each group.

	ABG (mm HG)	Oximetry (% Sat)	Notes
Group I	≤55	≤88	-
Group II	56-59	89	+ Additional disease criteria
Group III	>59	>89	Presumed noncovered

Qualification Tests

Blood oxygen levels are used to assess the beneficiary's degree of hypoxemia. Blood oxygen levels may be determined by either of two different test methods:

- Arterial blood gas (ABG) measurement; or,
- Pulse oximetry.

Arterial blood gas measurements are more accurate and therefore are the preferred measurement method. When both ABGs and oximetry are performed on the same day, the ABG value must be used for reimbursement qualification.

Blood oxygen values may be obtained using a variety of techniques. The LCD describes the following as acceptable oximetry testing methods:

- At rest and awake - often referred to as "spot" oximetry
- During exercise - requires a series of 3 tests done during a single testing session:
  - At rest, off oxygen - showing a non-qualifying result
  - Exercising, off oxygen - showing a qualifying result
  - Exercising, on oxygen - showing improvement in test results obtained while exercising off of oxygen
- During sleep
  - Overnight sleep oximetry
    - May be done in hospital or at home. Refer to the LCD for detailed information about home overnight sleep oximetry.
  - Titration Polysomnogram
    - Must be used for beneficiaries with concurrent (OSA) in order to establish that the beneficiary is in the "chronic stable state"
    - Refer to the Positive Airway Pressure Devices LCD for information about testing for OSA

Note: *The overnight sleep oximetry and the titration polysomnogram referenced above are not the same test as home sleep testing used for the diagnosis of Obstructive Sleep Apnea.*

Chronic Stable State (CSS)

All qualification testing must be performed while the beneficiary is in the CSS. CSS requires that all of the following be met:

- [O]ther forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required.
- Each patient must receive optimum therapy before long-term home oxygen therapy is ordered.
- It is expected that virtually all patients who qualify for home oxygen coverage for the first time under these guidelines have recently been discharged from a hospital where they submitted to arterial blood gas tests. If more than one arterial blood gas test is performed during the patient's hospital stay, the test result obtained closest to, but no earlier than two days prior to the hospital discharge date, is required as evidence of the need for home oxygen therapy. (Note: this is the only exception to the CSS requirement.)
- For those patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state, i.e., not during a period of an acute illness or an exacerbation of their underlying disease.

Please refer to the Local Coverage Determination (LCD) on Oxygen, the related Policy Article and the *Supplier Manual* for additional information about coverage, billing and documentation requirements. Thank you for your assistance in reducing the CERT error rate.

Sincerely,

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

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

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

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

April 2014 PECOS Dear Physician Letter (GEN)

Dear Physician:

The Centers for Medicare and Medicaid Services (CMS) is expanding claim edits for ordering/referring providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Effective January 1, 2014, specific edits were implemented that will prevent DMEPOS suppliers from receiving payment from Medicare for items that you have prescribed if you do not have a current enrollment in the Medicare Provider Enrollment, Chain and Ownership System (PECOS). Please help your Medicare patients to continue to be able to receive services you order by promptly enrolling in PECOS, or by updating your existing Medicare enrollment information if you have not done so recently.

For any DMEPOS item to qualify for coverage by Medicare it must be ordered by a physician or a practitioner who is eligible to order such item. To be eligible:

- Physicians or practitioners must be enrolled in PECOS and
- Must be registered in the system and
- Have a specialty that is eligible to order DMEPOS items for Medicare beneficiaries.

The provider specialties who can order DMEPOS items include:

- Doctor of Medicine or Osteopathy
- Doctor of Dental Medicine or Dental Surgery
- Doctor of Podiatric Medicine

- Physician Assistant
- Certified Clinical Nurse Specialist
- Nurse Practitioner
- Doctor of Optometry

In order to continue to order DMEPOS for Medicare beneficiaries, you will have to enroll in the Medicare program or "revalidate" your Medicare enrollment information. You may do so by:

- Using Internet-based PECOS, or
- By filling out the appropriate Medicare provider enrollment application(s) and mailing it, along with any required information, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application.

To confirm if you have a current enrollment record in Medicare, contact your designated enrollment contractor or you can go on-line, using Internet-based PECOS, to view your enrollment record. While viewing your PECOS record, take time to ensure that your NPI and name are listed correctly. Update your enrollment record with any necessary corrections.

We remind you that your enrollment in PECOS is required for your patients to receive their Medicare covered benefits for DMEPOS items. For additional information, consult with your Local A/B Medicare Administrative Contractor.

Sincerely,
Paul J. Hughes, MD

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

Robert D. Hoover, Jr., MD, MPH, FACP
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CGS Administrators, LLC

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National Government Services

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

April 2014 - Dear Physician - CERT/Therapeutic Shoes for Persons with Diabetes (SPE)

Dear Physician:

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

Medicare covers therapeutic shoes and inserts for persons with diabetes as established by the *Social Security Act* §1861(s) (12). You may access the Therapeutic Shoes for Persons with Diabetes (TSPD) LCD and Related Policy Article on the CMS web site under the Medicare Coverage Database. In order for your patient to qualify for these shoes and inserts, Medicare statute mandates specific coverage and documentation requirements that must be met.

The most common CERT errors center on missing documentation from the certifying physician of the patient having diabetes, the existence of one or more of the conditions for coverage and the therapeutic plan of care. Three criteria are critical to coverage and form the majority of physician-related CERT errors:

1. Documenting your management of the beneficiary's diabetes. You are considered the "Certifying Physician" and there is no substitute for this documentation requirement. The Certifying Physician, by statute, must be an M.D. or D.O. and not a nurse practitioner, physician assistant or clinical nurse specialist;

2. Documenting a qualifying foot condition. As opposed to the criteria above regarding documentation of the beneficiary's diabetes management, the documentation of the qualifying foot condition may come from your records or by your indication of agreement (signified by initialing and dating) with information from the medical records of an in-person visit with a podiatrist, another M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts.

3. Failure of the records to substantiate that an in-person visit occurred within 6 months prior to the delivery of the shoes or inserts.

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements from the policy have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and records from either your chart or that of another practitioner documenting a qualifying foot condition.

Please refer to the Local Coverage Determination (LCD) on Therapeutic Shoes for Persons with Diabetes (TSPD), the related Policy Article and the *Supplier Manual* for additional information about coverage, billing and documentation requirements. Thank you for your assistance in reducing the CERT error rate.

Sincerely,

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NHIC, Corp.

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Noridian Healthcare Solutions

May 2014 Face-to-Face and Written Order Requirements for High Cost DME Dear Physician Letter (GEN)

Note: *This revision adds information clarifying who may perform the in-person visit and the responsibilities of the ordering physician.*

Dear Physician,

For certain specified items of durable medical equipment the *Affordable Care Act* requires that an in-person, face-to-face examination (F2F) documenting the need for the item must have occurred sometime during the six (6) months prior to the order for the item. The purpose of this letter is to provide a summary of these requirements.

A F2F examination meeting the requirements discussed below is required each time a new prescription for one of the specified items is required. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the order for the accessory, supply, drug, etc.
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy
- When an item is replaced
- When there is a change in the supplier
- When required by state law

These requirements are effective for all new orders (prescriptions) for the specified items created on or after July 1, 2013.

Face-To-Face Examination Requirements

The physician must have a face-to-face examination with the beneficiary in the six (6) months prior to the date of the written order for the specified items of DME.

This face-to-face requirement includes examinations conducted via the Centers for Medicare & Medicaid Services (CMS)-approved use of telehealth examinations (as described in Chapter 15 of the *Medicare Benefit Policy Manual* and Chapter 12 of the *Medicare Claims Processing Manual* - CMS Internet-Only Manuals, Publ. 100-02 and 100-04, respectively).

For the physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face 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.
- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.
- 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.
- The prescriber must provide a copy of the face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item can be delivered.

Prescription (order) Requirements

These items require a written order prior to delivery (WOPD). A WOPD is the standard Medicare detailed written order, which must be completed and in the DMEPOS supplier's possession BEFORE the item can be delivered. The prescription (order) for the DME must meet all requirements for a WOPD and 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
- 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:

- 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 DME items do not have this NPI requirement.

Date and Timing Requirements

There are specific date and timing issues:

- The date of the F2F 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 F2F 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 (DOS).

- ALL DMEPOS suppliers must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

This letter is intended to be a general summary. It is not intended to take the place of the law, regulations, or national and local coverage determinations. Detailed information about these requirements can be found on the CMS web site **http://www.cms.gov** or on the DME contractors' web site.

Sincerely,

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Noridian Healthcare Solutions

TABLE A: DME List of Specified Covered Items

The DME list of Specified Covered Items is as follows. The original list was at 77 FR 44798. This original list contains some codes that have been deleted or that were made not valid for Medicare (*) in the interim while some other codes have had narrative changes (**). Updates to the list will be made as CMS releases revisions.

Refer to the Pricing, Data Analysis and Coding Contractor web site for information on coding at **http://www.dmepdac.com**

HCPCS Code	Description
E0185	Gel or gel-like pressure mattress pad
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad
E0194	Air fluidized bed
E0197	Air pressure pad for mattress standard length and width
E0198	Water pressure pad for mattress standard length and width
E0199	Dry pressure pad for mattress standard length and width
E0250	Hospital bed fixed height with any type of side rails, mattress
E0251	Hospital bed fixed height with any type side rails without mattress
E0255	Hospital bed variable height with any type side rails with mattress
E0256	Hospital bed variable height with any type side rails without mattress
E0260	Hospital bed semi-electric (Head and foot adjustment) with any type side rails with mattress
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress
E0265	Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress
E0266	Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress
E0290	Hospital bed fixed height without rails with mattress
E0291	Hospital bed fixed height without rail without mattress
E0292	Hospital bed variable height without rail without mattress
E0293	Hospital bed variable height without rail with mattress
E0294	Hospital bed semi-electric (head and foot adjustment) without rail with mattress
E0295	Hospital bed semi-electric (head and foot adjustment) without rail without mattress
E0296	Hospital bed total electric (head, foot and height adjustments) without rail with mattress
E0297	Hospital bed total electric (head, foot and height adjustments) without rail without mattress
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, without mattress
E0302	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress
E0303	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, with mattress
E0304	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, with mattress
E0424	Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor,

HCPCS Code	Description
	content gauge, cannula or mask, and tubing
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (1 months supply)
E0442	Oxygen contents, liquid (1 months supply)
E0443	Portable Oxygen contents, gas (1 months supply)
E0444	Portable oxygen contents, liquid (1 months supply)
E0450	Volume control ventilator without pressure support used with invasive interface
E0457	Chest shell
E0459	Chest wrap
E0460	Negative pressure ventilator portable or stationary
E0461	Volume control ventilator without pressure support node for a noninvasive interface
E0462	Rocking bed with or without side rail
E0463	Pressure support ventilator with volume control mode used for invasive surfaces
E0464	Pressure support vent with volume control mode used for noninvasive surfaces
E0470	Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface
E0471	Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface
E0480	Percussor electric/pneumatic home model
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High Frequency chest wall oscillation air pulse generator system
E0484	Oscillatory positive expiratory device, non-electric
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic, large volume
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter
E0585	Nebulizer with compressor & heater
E0601	Continuous airway pressure device
E0607	Home blood glucose monitor
E0627	Seat lift mechanism incorporated lift-chair
E0628	Separate Seat lift mechanism for patient owned furniture electric
E0629	Separate seat lift mechanism for patient owned furniture non-electric
E0636	Multi positional patient support system, with integrated lift, patient accessible controls
E0650	Pneumatic compressor non-segmental home model
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0655	Non- segmental pneumatic appliance for use with pneumatic compressor on half arm
E0656	Non- segmental pneumatic appliance for use with pneumatic compressor on trunk
E0657	Non- segmental pneumatic appliance for use with pneumatic compressor chest
E0660	Non- segmental pneumatic appliance for use with pneumatic compressor on full leg
E0665	Non- segmental pneumatic appliance for use with pneumatic compressor on full arm
E0666	Non- segmental pneumatic appliance for use with pneumatic compressor on half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full-leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg
E0671	Segmental gradient pressure pneumatic appliance full leg
E0672	Segmental gradient pressure pneumatic appliance full arm
E0673	Segmental gradient pressure pneumatic appliance half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel treatment 4 foot panel
E0693	Ultraviolet light therapy system panel treatment 6 foot panel
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application

HCPCS Code	Description
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0840	Tract frame attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958**	Manual wheelchair accessory, one-arm drive attachment
E0959**	Manual wheelchair accessory-adapter for Amputee
E0960**	Manual wheelchair accessory, shoulder harness/strap
E0961**	Manual wheelchair accessory wheel lock brake extension handle
E0966**	Manual wheelchair accessory, headrest extension
E0967**	Manual wheelchair accessory, hand rim with projections
E0968*	Commode seat, wheelchair
E0969*	Narrowing device wheelchair
E0971**	Manual wheelchair accessory anti-tipping device
E0973**	Manual wheelchair accessory, adjustable height, detachable armrest
E0974**	Manual wheelchair accessory anti-rollback device
E0978*	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap
E0980*	Manual wheelchair accessory safety vest
E0981**	Manual wheelchair accessory Seat upholstery, replacement only
E0982**	Manual wheelchair accessory, back upholstery, replacement only
E0983**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control
E0984**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986**	Manual wheelchair accessory, push activated power assist
E0990**	Manual wheelchair accessory, elevating leg rest
E0992**	Manual wheelchair accessory, elevating leg rest solid seat insert
E0994*	Arm rest
E1014	Reclining back, addition to pediatric size wheelchair
E1015	Shock absorber for manual wheelchair
E1020	Residual limb support system for wheelchair
E1028**	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029**	Wheelchair accessory, ventilator tray
E1030**	Wheelchair accessory, ventilator tray, gimbaled
E1031	Rollabout chair, any and all types with castors 5” or greater
E1035**	Multi-positional patient transfer system with integrated seat operated by care giver
E1036**	Patient transfer system
E1037	Transport chair, pediatric size
E1038**	Transport chair, adult size up to 300lb
E1039**	Transport chair, adult size heavy duty >300lb
E1161	Manual Adult size wheelchair includes tilt in space
E1227*	Special height arm for wheelchair
E1228*	Special back height for wheelchair
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233**	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system

HCPCS Code	Description
E1296*	Special sized wheelchair seat height
E1297*	Special sized wheelchair seat depth by upholstery
E1298*	Special sized wheelchair seat depth and/or width by construction
E1310**	Whirlpool non-portable
E2502**	Speech Generating Devices prerecord messages between 8 and 20 Minutes
E2506**	Speech Generating Devices prerecord messages over 40 minutes
E2508**	Speech Generating Devices message through spelling, manual type
E2510**	Speech Generating Devices synthesized with multiple message methods
E2227**	Rigid pediatric wheelchair adjustable
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength ltwt wheelchair
K0005	Ultra Lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base
K0606**	AED garment with electronic analysis
K0730	Controlled dose inhalation drug delivery system

Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act - Revised - DME MAC Joint Publication (GEN)

Note: *This revision adds information clarifying who may perform the in-person visit and the responsibilities of the ordering physician.*

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 within the six (6) months prior to the written order for certain items of DME (Refer to Table A for a list of items).

A 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
- When required by state law

The first bullet above, 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. This means that all Medicare payment requirements must be met, the same as any other item initially covered by Medicare.

These *Affordable Care Act* requirements are effective for claims for all of the specified items that require a new order (prescription) on or after July 1, 2013. Enforcement of these rules related to the face-to-face examination requirement and face-to-face documentation is delayed until a date to be announced by CMS in Calendar Year 2014. This delay in enforcement does not apply to the prescription requirements for a Written Order Prior to Delivery or to the requirement to include the prescriber's NPI on the prescription.

ACA 6407 also contains provisions requiring that a physician verify that a face-to-face examination performed by a PA, NP or CNS was done within the 6 months prior to the creation of a prescription for the specified item(s). This article does not address these provisions in detail. Additional information addressing physician verification will be forthcoming.

Face-To-Face Examination Requirements

The physician must have a face-to-face examination with the beneficiary in the six (6) months prior to the date of the written order for the specified items of DME.

This face-to-face requirement includes examinations conducted via the Centers for Medicare & Medicaid Services (CMS)-approved use of telehealth examinations (as described in Chapter 15 of the *Medicare Benefit Policy Manual* and Chapter 12 of the *Medicare Claims Processing Manual* - CMS Internet-Only Manuals, Publ. 100-02 and 100-04, respectively).

The DMEPOS supplier must have documentation of both the face-to-face visit and completed written order prior to delivery (WOPD) in their file prior to the delivery of these items.

For the physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face 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.
- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.
- 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.
- The prescriber must provide a copy of the face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item can be delivered.

Prescription (order) Requirements

These specified items require a written order that must be obtained prior to delivery (WOPD). A WOPD is a standard Medicare detailed written order, which must be completed and in the DMEPOS supplier's possession BEFORE the item is delivered. The prescription (order) for the DME 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
- 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:

- 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

For any of the specified items affected by this face-to-face requirement to be covered by Medicare, a written, signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as 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.

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, some of which are subject to these new order requirements. For example, oxygen concentrators (E1390) are often ordered in conjunction with portable oxygen (E0431). Orders for code E0431 require inclusion of the NPI while orders for E1390 do not.

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 these face-to-face requirements and prescription requirements that do not meet the requirements specified above will be denied as statutorily noncovered - failed to meet statutory requirements.

Local Coverage Determinations (LCD)

LCDs that contain items subject to these requirements are:

- Automatic External Defibrillators
- Cervical Traction Devices
- External Infusion Pumps
- High-frequency Chest Wall Oscillation Devices
- Home Glucose Monitors
- Hospital Beds
- Manual In-exsufflation Devices
- Manual Wheelchairs
- Nebulizers
- Osteogenesis Stimulators
- Oxygen
- Patient Lifts
- Pneumatic Compression Devices
- Positive Airway Pressure Devices
- Pressure Reducing Support Surfaces
- Respiratory Assist Devices
- Seat Lift Mechanisms
- Speech Generating Devices
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Wheelchair options and Accessories

These LCDs will be updated to include the requirements at a future date.

Numerous items are not included in a specific LCD. Some have coverage criteria described by National Coverage Determinations. Others have coverage determined on a case-by-case or individual-claim basis. This article and the associated CMS publications will constitute notice of these requirements for all of the applicable codes.

Refer to the applicable LCD, NCD and/or the *Supplier Manual* for additional information about WOPD requirements.

TABLE A: DME List of Specified Covered Items

The DME list of Specified Covered Items is as follows. The original list was at 77 FR 44798. This original list contains some codes (codes marked with an "*") that have been deleted or that were made not valid for Medicare while other codes (codes marked with an "**") have had narrative changes. Updates to the list will be made as CMS releases revisions.

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E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing
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E0692	Ultraviolet light therapy system panel treatment 4 foot panel
E0693	Ultraviolet light therapy system panel treatment 6 foot panel
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0840	Tract frame attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958**	Manual wheelchair accessory, one-arm drive attachment
E0959**	Manual wheelchair accessory-adapter for Amputee
E0960**	Manual wheelchair accessory, shoulder harness/strap
E0961**	Manual wheelchair accessory wheel lock brake extension handle
E0966**	Manual wheelchair accessory, headrest extension
E0967**	Manual wheelchair accessory, hand rim with projections
E0968*	Commode seat, wheelchair
E0969*	Narrowing device wheelchair
E0971**	Manual wheelchair accessory anti-tipping device
E0973**	Manual wheelchair accessory, adjustable height, detachable armrest
E0974**	Manual wheelchair accessory anti-rollback device
E0978*	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap

HCPCS Code	Description
E0980*	Manual wheelchair accessory safety vest
E0981**	Manual wheelchair accessory Seat upholstery, replacement only
E0982**	Manual wheelchair accessory, back upholstery, replacement only
E0983**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control
E0984**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986**	Manual wheelchair accessory, push activated power assist
E0990**	Manual wheelchair accessory, elevating leg rest
E0992**	Manual wheelchair accessory, elevating leg rest solid seat insert
E0994*	Arm rest
E1014	Reclining back, addition to pediatric size wheelchair
E1015	Shock absorber for manual wheelchair
E1020	Residual limb support system for wheelchair
E1028**	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029**	Wheelchair accessory, ventilator tray
E1030**	Wheelchair accessory, ventilator tray, gimbaled
E1031	Rollabout chair, any and all types with castors 5” or greater
E1035**	Multi-positional patient transfer system with integrated seat operated by care giver
E1036**	Patient transfer system
E1037	Transport chair, pediatric size
E1038**	Transport chair, adult size up to 300lb
E1039**	Transport chair, adult size heavy duty >300lb
E1161	Manual Adult size wheelchair includes tilt in space
E1227*	Special height arm for wheelchair
E1228*	Special back height for wheelchair
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233**	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1296*	Special sized wheelchair seat height
E1297*	Special sized wheelchair seat depth by upholstery
E1298*	Special sized wheelchair seat depth and/or width by construction
E1310**	Whirlpool non-portable
E2502**	Speech Generating Devices prerecord messages between 8 and 20 Minutes
E2506**	Speech Generating Devices prerecord messages over 40 minutes
E2508**	Speech Generating Devices message through spelling, manual type
E2510**	Speech Generating Devices synthesized with multiple message methods
E2227**	Rigid pediatric wheelchair adjustable
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength ltwt wheelchair
K0005	Ultra Lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base
K0606**	AED garment with electronic analysis
K0730	Controlled dose inhalation drug delivery system

In-person Visit Requirement for Section 6407 of the Affordable Care Act - Clarification - Joint DME MAC Publication (GEN)

Section 6407 of the *Affordable Care Act* (ACA 6407) requires that an in-person or face-to-face encounter must occur within the six months preceding the written order. There have been questions about whether this in-person visit must be conducted by the prescribing physician or whether an in in-person visit with another treating practitioner may be acceptable to fulfill this requirement.

CMS has clarified that the treating practitioner that conducted the face-to-face examination does not need to be the prescriber of the order for the DME item. However the prescriber must have knowledge and documentation of the face-to-face examination that was conducted.

Refer to the previously published bulletin and the applicable medical policy for additional information about ACA 6407.

This information will be updated in the previously published material.

LCD and Policy Article Revisions Summary for March 20, 2014 (GEN)

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

Cervical Traction Devices

LCD

Revision Effective Date: 07/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Information that item(s) in policy are subject to ACA 6407 requirements
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information

Policy Article

Revision Effective Date: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Non-coverage guidance for L5969
HCPCS CODES AND MODIFIERS:
Added: L5969
Revised: HCPCS Narrative of L5668

Policy Article

Revision Effective Date: 01/01/2014
CODING GUIDELINES:
Added: Instructions for use of code L5969
Added: Requirement for PDAC coding verification for L5969

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 01/01/14
HCPCS CODES AND MODIFIERS:
Added: Q0161
Discontinued: Q0165, Q0168, Q0170, Q0171, Q0172, Q0176 and Q0178

Power Mobility Devices

LCD

Revision Effective Date: 10/01/2013 (March 2014 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Information that item(s) in policy are subject to ACA 6407 requirements (effective 07/01/2013)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 10/01/2013 (March 2014 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements (effective 07/01/2013)

Pressure Reducing Support Surfaces - Group 1

LCD

Revision Effective Date: 07/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Information that item(s) in policy are subject to ACA 6407 requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information

Policy Article

Revision Effective Date: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements

Respiratory Assist Devices

LCD

Revision Effective Date: 07/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Information that item(s) in policy are subject to ACA 6407 requirements
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information

Policy Article

Revision Effective Date: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements

Seat Lift Mechanisms

LCD

Revision Effective Date: 07/01/2013
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information

Policy Article

Revision Effective Date: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements

Transcutaneous Electrical Nerve Stimulators (TENS)

LCD

Revision Effective Date: 10/01/2013 (March 2014 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 07/01/2013 (March 2014 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: ACA 6407 requirements

Wheelchair Seating

LCD

Revision Effective Date: 07/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Information that item(s) in policy are subject to ACA 6407 requirements
Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information
Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables

Policy Article

Revision Effective Date: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements
CODING GUIDELINES:
Changed: Clerical change from "vertical" to "horizontal" regarding HCPCS E2613-E2616

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

LCD and Policy Article Revisions Summary for March 27, 2014 (GEN)

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

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 01/01/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: References to off-the-shelf (OTS) and custom fitted
Added: New and revised 2014 HCPCS codes to coverage statements
Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables
HCPCS CODES AND MODIFIERS:
Added: L4361, L4387, L4397

For the following codes, the descriptor was changed: L1902, L1904, L1906, L1907, L4350, L4360, L4370, L4386, L4396, L4398
DOCUMENTATION REQUIREMENTS:
Added: Documentation requirement for custom fitted vs. OTS

Policy Article

Revision Effective Date: 01/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Correct coding statement for prefabricated orthoses
Added: Denial statement for incorrect coding
CODING GUIDELINES:
Added: Definitions of off-the-shelf and custom fitted
Added: Respective off-the-shelf and custom fitted codes to coding statements
Added: Definitions for minimal self-adjustment, substantial modification and kits

Knee Orthoses

LCD

Revision Effective Date: 01/01/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: References to off-the-shelf (OTS) and custom fitted
Added: HCPCS codes for OTS and custom fitted to their respective coverage statements, including correct coding statement for custom fitted items
Added: HCPCS codes to the Tables for Addition Codes-Eligible for Separate Payment, and Not Reasonable and Necessary
Revised: Specific ICD-9 diagnosis codes contained in the narrative are replaced with a reference to the applicable diagnosis code tables
HCPCS CODES AND MODIFIERS:
Added: L1812, L1833, L1848
For the following codes, the descriptor was changed: L1810, L1830, L1832, L1836, L1843, L1845, L1847, L1850
DOCUMENTATION REQUIREMENTS:
Added: Documentation requirement for custom fitted vs. OTS

Policy Article

Revision Effective Date: 01/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Correct coding statement for prefabricated orthoses
Added: Denial statement for incorrect coding
Added: L1812 and L1833 to the reasonable useful lifetime table
CODING GUIDELINES:
Added: Definitions for off-the-shelf and custom fitted
Added: Definitions for minimal self-adjustment, substantial modification and kits
Added: L1812, L1833, L1848 base codes and the not separately payable codes to the table

Oral Anticancer Drugs

Policy Article

Revision Effective Date: 03/01/2014
ICD-9 CODES THAT ARE COVERED:
Deleted: ICD-9 diagnosis code V23.89. Inadvertent addition of an inappropriate ICD-9-CM code

Pneumatic Compression Devices

LCD

Revision Effective Date: 07/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Information that item(s) in policy are subject to ACA 6407 requirements
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: ACA 6407 information

Policy Article

Revision Effective Date: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 information

Spinal Orthoses: TLSO and LSO

LCD

Revision Effective Date: 01/01/2014
COVERAGE INDICATIONS, LIMITATIONS, and/or MEDICAL NECESSITY:
Added: References to off-the-shelf (OTS) and custom fitted
Added: HCPCS codes for OTS and custom fitted to their respective coverage statements, including correct coding statement for custom fitted items
HCPCS CODES AND MODIFIERS:
Added: L0455, L0457, L0467, L0469, L0623, L0641, L0642, L0643, L0648, L0649, L0650 and L0651
Revised: HCPCS Narrative of L0450, L0454, L0456, L0460, L0466, L0468, L0621, L0625, L0626, L0627, L0628, L0630, L0631, L0633, L0637, L0639 and L0984
DOCUMENTATION REQUIREMENTS:
Added: Documentation requirement for custom fitted vs. OTS

Policy Article

Revision Effective Date: 01/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Correct coding statement for prefabricated orthoses
CODING GUIDELINES:
Added: Definitions for off-the-shelf and custom fitted
Added: Definitions for minimal self-adjustment, substantial modification and kits

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

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

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

DME MAC A Medical Review has been performing a service-specific Documentation Compliance Review (DCR) of HCPCS Codes A4253 (Blood glucose test strips) claims. This type of review is conducted when data analysis indicates there is a pattern of insufficient documentation in a product category. This review was initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

Documentation Requested

The following documentation is requested to perform the DCR:

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

Current Review Results

These findings are for claims processed from January 01, 2014 through March 31, 2014:

- The review involved DCRs of 8,748 claims (including reopenings)

- 1,365 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR) resulting in a 16% denial rate.
- Of the 7,383 claims reviewed, 4,831 claims were denied resulting in a claim denial rate of 65%.

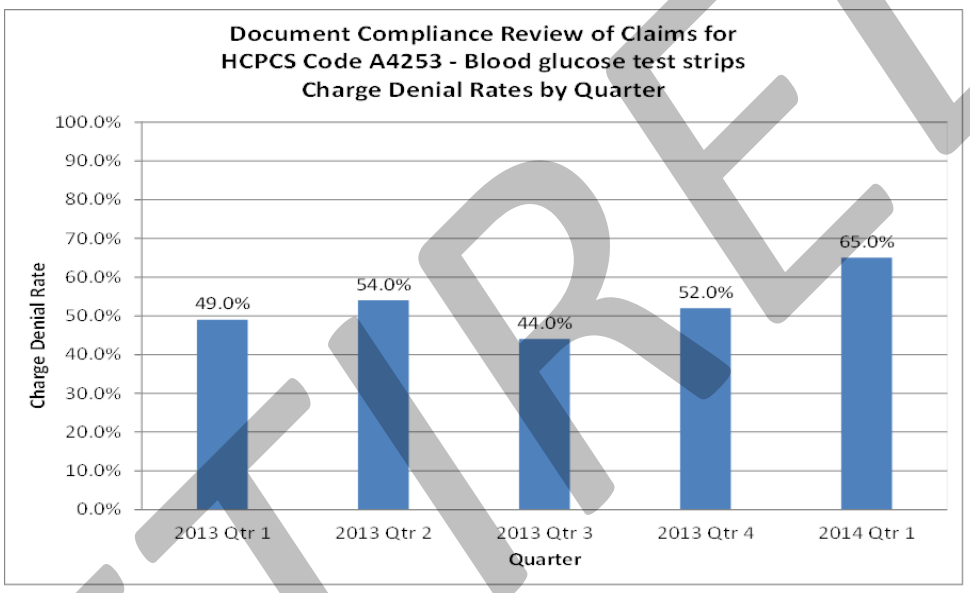
Primary Reasons for Denial

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

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

Denial Rate - Historical Results

The following graph depicts the Charge Denial rate from previous quarters to current. Current results are consistent with historical results:



Next Step

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

Educational References

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

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

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

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

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

  - Chapter 10: includes information regarding documentation requirements.

- DME MAC A Glucose Monitor Tutorial - **http://www.medicarenhic.com/dme/eduonline.aspx#tutorials**
- DME MAC A Glucose Documentation Podcast - **http://www.medicarenhic.com/dme/eduonline.aspx#podcast**
- Results of Documentation Compliance Review (DCR) of Claims for HCPCS A4253 **http://www.medicarenhic.com/viewdoc.aspx?id=2569**
- Documentation Reminder - Glucose Monitor Logs for High-Utilization Claims **http://www.medicarenhic.com/viewdoc.aspx?id=2319**
- Glucose Monitors and Supplies - Dear Physician Letter - **http://www.medicarenhic.com/dme/phyletters.aspx**

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

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

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

Documentation Requested

The following documentation is requested to perform the DCR:

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

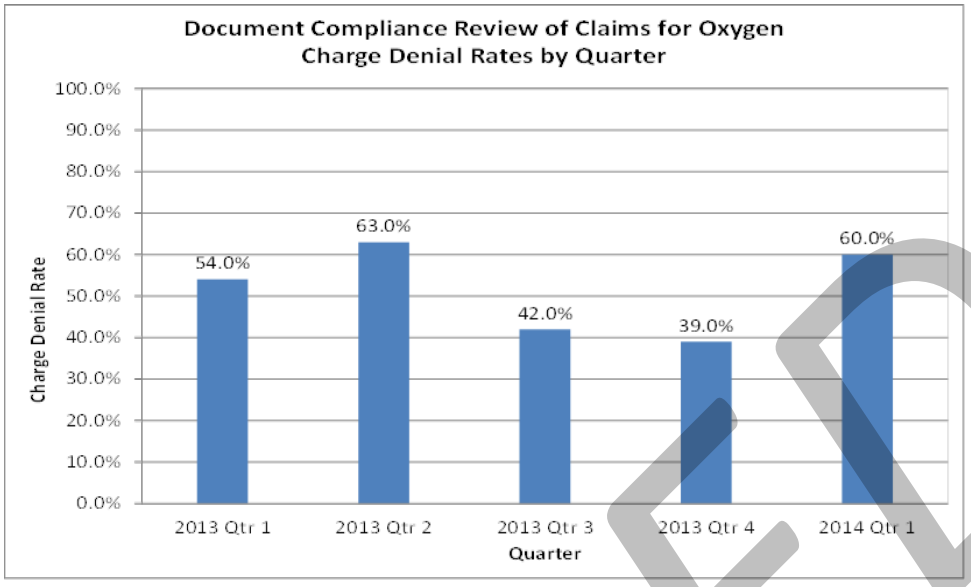
Current Review Results

These findings are for claims processed from January 01, 2014 through March 31, 2014:

- The review involved DCRs of 4,831 claims (including reopenings)
- 479 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR) resulting in a 10% denial rate
- Of the remaining 3902 claims reviewed, 2,362 claims were denied resulting in a claim denial rate of 60%

Denial Rate - Historical Results

The following graph depicts the Charge Denial rate from previous quarters to current. Steady improvement has been noted:



Primary Reasons for Denial

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

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

Next Step

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

Educational References

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

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768) **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**
- The *DME MAC Jurisdiction A Supplier Manual* - **http://www.medicarenhic.com/dme/supmandownload.aspx**
  - "Welcome Page" provides valuable information to the CMS Web sites
  - Chapter 10: includes information regarding documentation requirements
- Home Oxygen Initial Qualification Testing - **http://www.medicarenhic.com/viewdoc.aspx?id=2667**
- Oxygen and Oxygen Equipment Documentation - **http://www.medicarenhic.com/viewdoc.aspx?id=2578**
- 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) - **http://www.medicarenhic.com/viewdoc.aspx?id=349**
- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390 **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

- Payment Rules Reminder - Home Oxygen Initial Qualification Testing - Joint DME MAC Publication
  http://www.medicarenhic.com/viewdoc.aspx?id=2499

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 50.9%. A summary of findings was published on the NHIC, Corp. web site on January 21, 2014. Based on this result, a widespread prepayment review was continued.

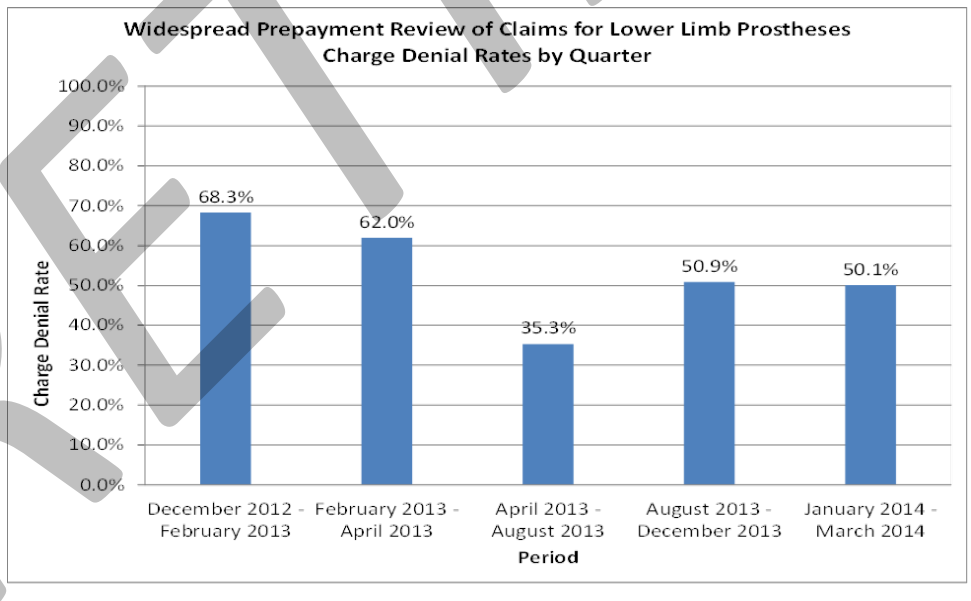
Current Review Results

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 177 claims submitted by 114 suppliers for claims processed January 2014 to March 2014. Responses to the Additional Documentation Request (ADR) were not received for 33 (18%) of the claims. For the remaining 144 claims, 33 claims were allowed and 111 were denied resulting in a claim denial rate of 77%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 50.1%.

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

- 36.9% of the denied claims had no medical record information submitted.

Evaluation/assessment Documentation

- 9% of the denied claims had no prosthetist records submitted.

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

- 24.3% of the denied claims had clinical records submitted but the records did not justify the functional level of the billed item.

Proof of delivery

- 7% 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 or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the evaluation/assessment documentation for the functional level of item(s) billed, which details the functional level of the items billed.
Missing: Clinical documentation to support functional level of the device and to corroborate the prosthetist's records. Also missing was proof of delivery, which validates that the beneficiary received the items that were billed.

Example 2:

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 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; Clinical documentation to support functional level of the device; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed.
Missing: The prosthetist's evaluation/assessment documentation detailing the functional levels of the items 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* - **http://www.medicarenhic.com/dme/supmandownload.aspx**
  - Chapter 10: Includes Standard Documentation Requirements
- Dear Physician Letter - Documentation of Artificial Limbs - **http://www.medicarenhic.com/dme/phyletters.aspx**
- CERT Errors (Monthly Publications) -**http://www.medicarenhic.com/dme/dmerccertrec.aspx**
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (Posted March 06, 2013, June 14, 2013, October 25, 2013, January 21, 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 Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277) (MOB)

Historical Review Results

The previous quarterly findings covered the period from August 1, 2013 through December 31, 2013 and resulted in a 72.3% Charge Denial Rate (CDR).

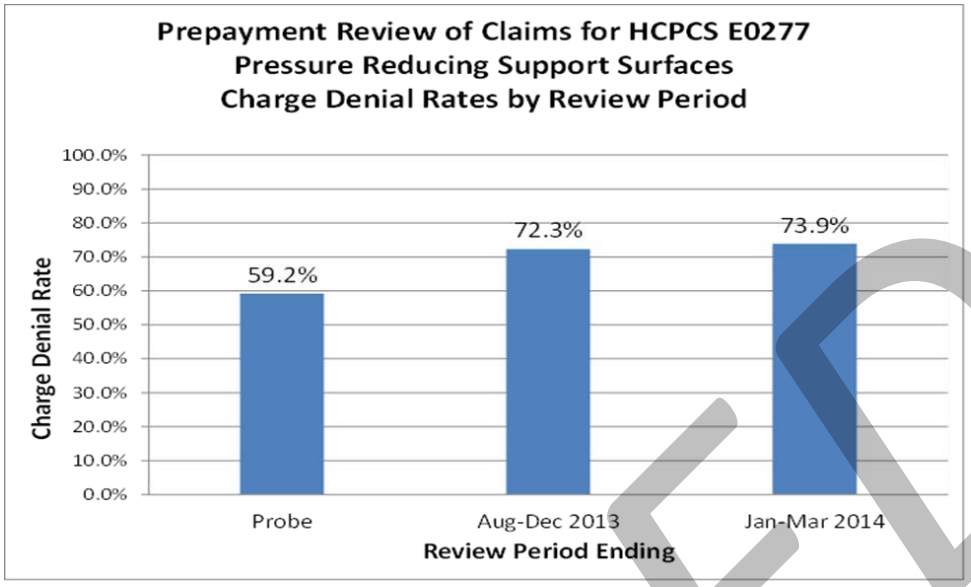
Current Review Results

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 January 1, 2014 through March 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 123 claims submitted by 57 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 42 (34%) of the claims. For the remaining 81 claims, 25 claims were allowed and 56 were denied resulting in a claim denial rate of 69%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 73.9%.

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

- 43% 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.
    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.
- 15% of the denied claims did not include medical documentation.
- 3% of the denied claims contained medical documentation that was illegible.

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.
- 5% of the denied claims did not include a detailed written order.
- 3% of the denied claims contained a detailed written order that was dated after delivery.

Proof of Delivery Issues

- 4% of the denied claims did not include proof of delivery.
- 3% of the denied claims contained proof of delivery that was not signed by the beneficiary.
- 6% of the denied claims contained proof of delivery that contained a delivery date that was different than the date of service.

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: The supplier submitted 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, and medical records from a hospital stay.

Missing: The documentation submitted for review does not include a proof of delivery. The hospital medical records did not contain enough information to determine that the beneficiary met the coverage criteria: 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, the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or 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: The supplier submitted 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 several visiting nurse notes; and 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 claim did not include a detailed written order that was dated before the date of delivery. The visiting nurse notes did not contain enough information to determine that the beneficiary met the coverage criteria: 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, the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or 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 3

Received: The supplier submitted a detailed written order which includes the beneficiary's name, detailed description of item, 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; 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 claim did not include any medical records. Therefore it could not be determined that the beneficiary met the coverage criteria: 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, the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or 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 submitted proof of delivery indicates that the beneficiary received the group 2 support surface on a different date than 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**
- 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/dme/duc.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**
- 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 (Published 02/25/2014) - **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

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

Historical Review Results

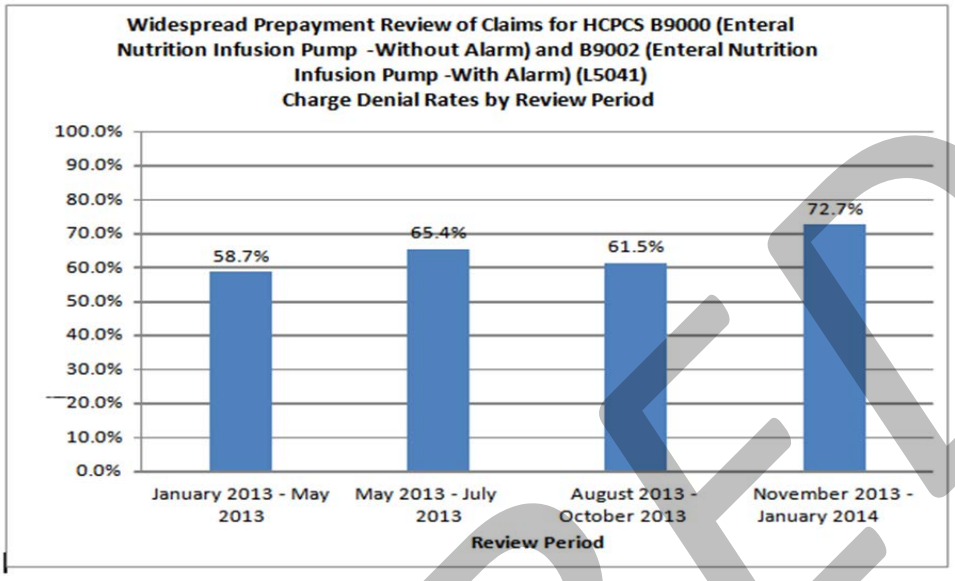
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed August 01, 2013 thru October 31, 2013 and resulted in a 61.5% 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 November 01, 2013 through January 31, 2014.

The review involved prepayment complex medical review of 817 claims submitted by 156 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 356 (43%) of the claims. For the remaining 461 claims, 111 claims were allowed and 350 were denied/partially denied resulting in a claim denial rate of 76%. 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 72.7%.

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

- 28% of the denied claims did not have any medical record documentation submitted.
- 11% of the denied claims had insufficient clinical documentation to justify the LCD criteria:
    a. a permanent non-function or disease of the structures that normally permit food to reach the small bowel
    b. a disease of the small bowel which impairs digestion and absorption of an oral diet

  Note: *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 2% of the claims denied for statutory denial - did not meet prosthetic benefit requirement. Beneficiary able to tolerate oral nutrition 75% to 100% in each meal serving

Proof of Delivery

- 26% of the denied claims had no Proof of Delivery (POD).
- 1% of the claims had incomplete delivery information.
- No proof of receipt by the beneficiary.

Detailed Written Order Issues

- 15% of the denied claims had missing detailed written orders. 4% of the denied claims had incomplete detailed written orders Date of the detailed order was incomplete (missing month or year)
- 3% of the denied claims, physician signature could not be authenticated.

DME Information Form

- 9% Missing DME Information Form

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: Date of signature on detailed physician order is after date of service

Example 2:

Received: Detailed physician order, Medical documentation, DIF.
Missing: Signature of physician on detailed order, Delivery ticket with signature and date for in person delivery

Example 3:

Received: CMS letter, laboratory values, admission sheet
Missing: Detailed physician order, DIF, medical documentation, delivery ticket with signature and date for in person delivery

Next Step

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

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

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

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

Educational References

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

- Enteral Nutrition (L5041) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (issued 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**
- Monthly CERT Error examples - **http://www.medicarenhic.com/dme/dmerccertrec.aspx**

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

Historical Review Results

DME MAC A Medical Review continues to review Nebulizers, with Compressor, based on the results of previous quarterly findings. The previous quarterly findings covered the period of August 1, 2013 through October 31, 2013 and resulted in a Charge Denial Rate (CDR) of 64.3%.

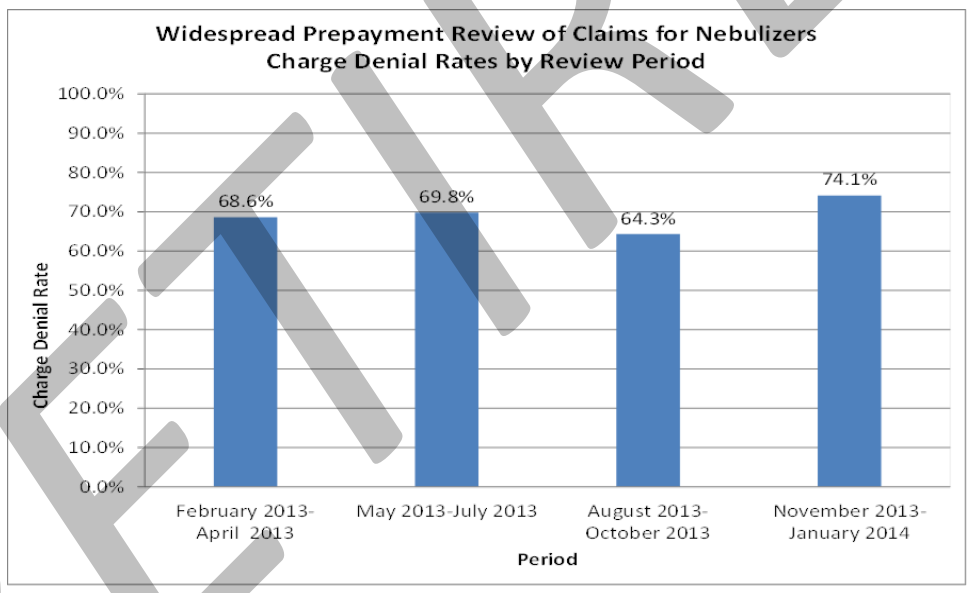
Current Review Results

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 November 1, 2013 through January 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 1340 claims submitted by 500 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 295 (22%) of the claims. For the remaining 1045 claims, 269 claims were allowed (26%) and 776 were denied/partially denied resulting in a claim denial rate of 75%. 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 74.1%.

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

- 29% of the denied claims were missing clinical information to support medical necessity.
  - No medical records were submitted
- 32% 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 list a payable diagnosis
    - 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
  - Unsigned typed note with just physician's typed name

Detailed Written Order Issues

- 3% of the denied claims were missing the detailed written order.
- 11% of the denied claims had an incomplete or invalid detailed written order. The following are specific issues identified:
  - Illegible copy of order
  - Start date after the date of service
  - Physician signature date was after the claim was submitted
  - Physician signature did not meet signature requirements including:
    - Illegible physician signature
    - Unable to authenticate physician signature with printed name and/or no signature log submitted.

Proof of Delivery Issues

- 4% of the denied claims were missing proof of delivery.
- 20% 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 signature and date of 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 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: Detailed written order with: beneficiary name, description of items to be dispensed, physician's legible signature, and date of signature.

Missing: Description of item to be dispensed was not detailed enough in order to determine the exact item ordered. No clinical notes to support reasonable and necessary use of a nebulizer. No proof of delivery to support the item ordered was received by the beneficiary.

Example 2:

Received: Detailed written order with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature; Clinical notes and proof of delivery.

Missing: Clinical notes do not explain reasonable and necessary use of a nebulizer. The date of delivery for this claim was after the date of service.

Example 3:

Received: Illegible Detailed written order, proof of delivery with: beneficiary name and address, description of item to be delivered.

Missing: No clinical notes to support reasonable and necessary use of a nebulizer. The proof of delivery for this claim was missing the beneficiary signature and date of signature.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for E0570 (Nebulizer, with Compressor). Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

Educational References

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

- Nebulizers LCD(L11499) and Policy Article (A24944) - **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**
- Results of Widespread Prepayment Review of Claims for E0570 (Posted March 15, 2013; June 28, 2013; September 13, 2013; December 12, 2013) - **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements. - **http://www.medicarenhic.com/dme/supmandownload.aspx**
- Monthly CERT Error examples - **http://www.medicarenhic.com/dme/dmerccertrec.aspx**
- Frequently Asked Questions (search word "nebulizer") - **http://www.medicarenhic.com/faqs.aspx?categories=DME**

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

Historical Review Results

DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of the previous review findings. The previous quarterly findings covered claims reviewed from October 2013 through December 2013 and resulted in a 67.6% Charge Denial Rate (CDR).

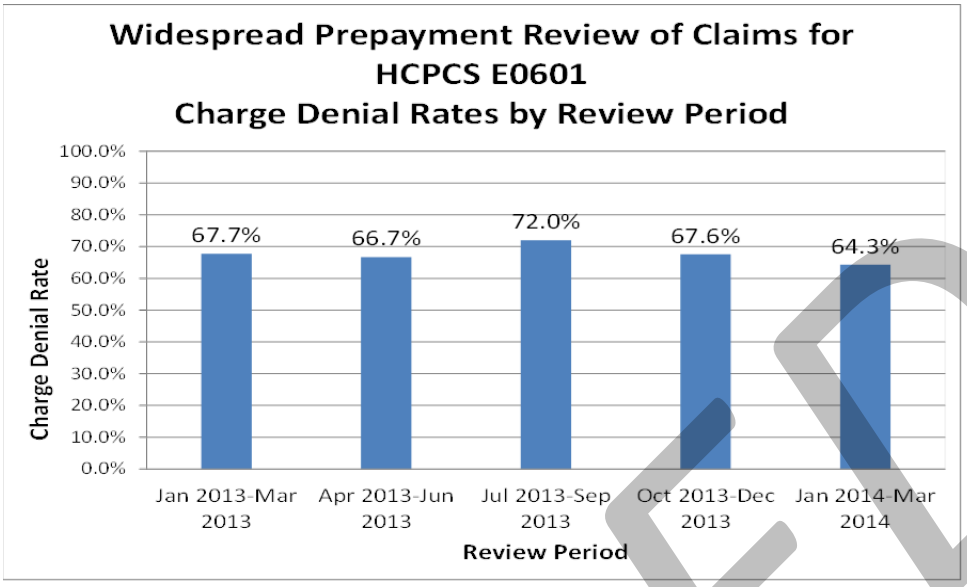
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from January 2014 through March 2014. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 1,456 claims submitted by 388 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 220 (15%) of the claims. Of the 1,236 claims for which responses were received, 417 claims were allowed and 819 were denied/partially denied. This resulted in a claim denial rate of 66.3%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 64.3%.

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

- 17.7% 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 Positive Airway Pressure Devices (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.

- 18.2% of the denied claims had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. The insufficient clinical documentation included:
    - Clinical documentation provided did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing presenting symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
    - Face-to-Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued benefit from sleep therapy.
    - Insufficient clinical documentation noted in Face-to-Face evaluations conducted by the treating physician in claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering Fee-for-Service (FFS) Medicare.

- 7.2% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.

- 0.6% of the denied claims had illegible Face-to-Face documents.

Detailed Written Order/Written Order Prior to Delivery Issues

- 0.7% of the denied claims did not include the Detailed Written Order.

- 45.8% of the denied claims had an incomplete Detailed Written Order, or for claims with a Date of Service on or after January 1, 2014, an incomplete Written Order Prior to Delivery. 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, or
    e. Physician signature and signature date

  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

- 0.5% of the denied claims had a Detailed Written Order which was illegible.

Sleep Study Documentation Issues

- 5.5% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 3.3% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 11.5% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 20.9% of the denied claims did not include evidence of instruction of proper use and care of the PAP device.
- 4.8% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 8.1% of the denied claims were missing Proof of Delivery.
- 6.7% 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.
- 1.2% of the denied claims were delivered after the Date of Service.
- 1.1% of the denied claims were delivered before the Date of Service.

Claim Examples

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

Example 1:

Received: Included in this claim are a 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 Face-to-Face does not contain a 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).

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 Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The Written Order Prior to Delivery is missing the prescribing practitioner's National Provider Identification (NPI).

Example 3:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order, a Medicare approved Sleep Study, and evidence of Training on the PAP device.
Missing: The Medicare approved Sleep Study included indicates an AHI of 5.2, but only 7 events, which does not meet the coverage criteria per the PAP LCD. The claim does not include a Proof of Delivery.

Next Step

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

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

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

Educational References

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

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528) LCD and Policy Article (A19815) - **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**
- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601): Posted 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**

Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (MOB)

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from July 01, 2013 through September 31, 2013 and resulted in a 52.8% Charge Denial Rate (CDR).

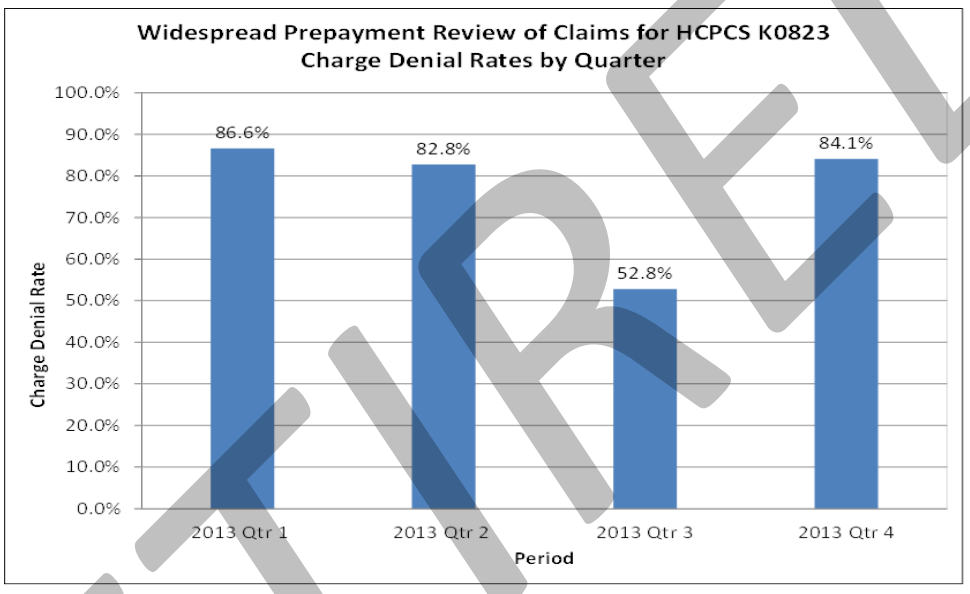
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings include claims with dates processed from October 01, 2013 through December 31, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 188 claims submitted by 78 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 60 (32%) of the ADR requests issued. Of the 128 claims for which responses were received, 16 of the claims were allowed and 112 of the claims were denied. This resulted in a claim denial rate of 88%. 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 84.1%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Face-to-Face Examination

- 69% of the denied claims had insufficient clinical documentation to support medical necessity:
  - 21% The Face-to-Face Examination did not specify objective measurements of the beneficiary's limitations for performing mobility related activities of daily living.
  - 15% The Face-to-Face Examination did not specify the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) within their home.
  - 15% The Face-to-Face Examination fails to specify that the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
  - 5% The Face-to-Face Examination fails to demonstrate that the beneficiary meets the coverage criteria for a captain's chair.
  - 5% The Face-to-Face Examination is not a comprehensive mobility examination.
- 12% 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.
- 6% of the denied claims were missing the Face-to-Face Examination.
- 5% of the denied claims included a Face-to-Face Examination that was not completed by the same practitioner that signed the 7-Element Order.
- 5% of the denied claims included an illegible Face-to-Face Examination.
- 4% of the denied claims included a Face-to-Face Examination that was missing the treating physician's signature.

7-Element Order

- 9% of the denied claims did not include confirmation the supplier received a copy of the 7-Element Order within 45 days after the completion of the Face-to-Face Clinical Evaluation as verified by a supplier date stamp or equivalent. A date stamp or equivalent was not present.
- 10% of the denied claims were missing an element of the 7-Element Order:
    - 5% The 7-Element Order contains an invalid date of the Face-to-Face Examination.
    - 3% The 7-Element Order is missing the length of need.
    - 2% The 7-Element Order is missing the date of Face-to-Face Examination.

LCMP Examination

- 21% 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.
- 11% of the denied claims contained medical documentation in which the treating physician did not state concurrence with the LCMP Examination, either in the Face-to-Face Documentation or by indicating concurrence with a dated signature on the LCMP Examination.
- 6% of the denied claims did not include confirmation the supplier received a copy of the LCMP Examination within 45 days of the completion of the Face-to-Face Exam; as verified by a supplier date stamp or equivalent.
- 4% of the denied claims were missing the OT/PT Signature and/or Signature Date on LCMP Examination.
- 2% of the denied claims were missing the treating physician's signature on the LCMP Examination.

Detailed Product Description (DPD)

- 12% 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.
- 6% of the denied claims did not include a DPD.

Proof of Delivery

- 8% of the denied claims were missing a Proof of Delivery.
- 2% of the denied claims had items listed on the delivery ticket that did not match the items listed on the (DPD) and/or the ADS letter.
- 2% of the denied claims contained a Proof of Delivery in which the delivery date did not match the Date of Service.
- 2% 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

- 6% of the denied claims did not include evidence of a Home Assessment being completed before or at the time of the delivery of the Power Wheel Chair.
- 2.5% of the denied claims had Home Assessments that did not demonstrate that the patient can adequately maneuver the device throughout the home in terms of the actual physical layout, doorway width, doorway thresholds and surfaces.
- 3% of the denied claims were missing a supplier's signature on the Home Assessment.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

Example 1

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Examination, LCMP Examination, Detailed Product Description, Home Assessment and Proof of Delivery.

Missing: The Face-to-Face Examination did not include documentation that demonstrated the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) within their home, does not indicate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker and fails to specify that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs). 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, 7-Element Order and LCMP Examination 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 is missing a date stamp (or equivalent) indicating when it was received by the supplier from the physician. The documentation does not include a signed and dated attestation by the supplier or licensed/certified medical professional (LCMP) stating they have no financial relationship with the supplier. The specialty evaluation completed by the licensed/certified medical professional (LCMP) did not have evidence of concurrence by the treating physician's documentation or by the treating physician's dated signature, therefore the evaluation was not taken into consideration as part of the Face-to-Face Examination.

Example 2

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Examination, LCMP Examination, Detailed Product Description, Home Assessment and Proof of Delivery.
Missing: The Face-to-Face Examination fails to specify that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs), did not specify objective measurements of the beneficiary's limitations and did not indicate that the use of a power operated vehicle (POV) has been excluded. The documentation does not include a signed and dated attestation by the supplier or licensed/certified medical professional (LCMP) stating they have no financial relationship with the supplier. The Proof of Delivery contains items that do not match the items ordered on DPD/or ADS Letter.

Example 3

Received: Documentation provided in this claim included: Face-to-Face Clinical Evaluation, Detailed Product Description, Home Assessment and the Proof of Delivery.
Missing: The documentation submitted for review does not include a Face-to-Face Mobility Examination. The 7-Element Order is missing the date of Face-to-Face Examination and length of need. The Detailed Product Description does not contain a sufficiently detailed description in order to identify the item(s) being delivered.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS K0823.

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

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

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

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

Educational References

NHIC Corp. DME MAC and CMS provide extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles - **http://www.medicarenhic.com/dme/dmerccertrec.aspx**
- Power Mobility Devices (L21271) LCD - **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**
- Power Mobility Devices - 7-Element Order (published 11/05/09) - **http://www.medicarenhic.com/viewdoc.aspx?id=560**
- Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios (published 04/05/13) **http://www.medicarenhic.com/viewdoc.aspx?id=1591**

- Power Mobility Devices Billing Reminder (published 01/11/08) - **http://www.medicarenhic.com/viewdoc.aspx?id=206**
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements - **http://www.medicarenhic.com/dme/supmandownload.aspx**
- Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (published 12/27/2013, 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**
- Frequently Asked Questions (search word PMD) - **http://www.medicarenhic.com/faqs.aspx?categories=DME**
- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network; ICN 905063 September 2011) - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf**
- Power Mobility Device Face-to-Face Examination Checklist (SE1112) **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1112.pdf**

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 October 1, 2013 through December 31, 2013 and resulted in a 44% Charge Denial Rate (CDR).

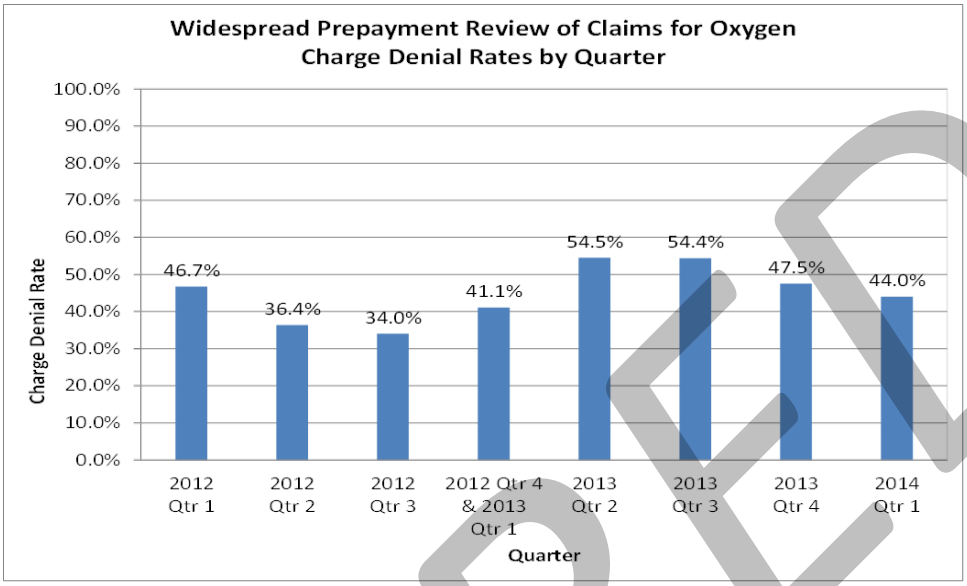
Current Review Results

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 January 1, 2014 through March 31, 2014.

The review involved prepayment complex medical review of 604 claims submitted by 106 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 355 (59%) of the claims. For the remaining 249 claims, 146 claims were allowed and 103 were denied resulting in a claim denial rate of 41%. 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 44%.

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.

Missing Documentation (57%)

Missing required physician visit per Local Coverage Determination (LCD) L11468

- 31% - Missing treating physician visit within 30 days prior to the date of the Initial Certification

Missing qualifying blood gas study per LCD L11468

- 15% - No documentation to validate oxygen testing

Missing required Certificate of Medical Necessity per LCD L11468

- 6% - Missing an Initial CMN or Initial CMN was incomplete

Missing valid proof of delivery per LCD L11468

- 5% - Missing valid delivery ticket

Written Order Prior to Delivery Requirements Not Met (6%)

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

- Written order was signed after the date of delivery
- Written order did not include the receipt date
- Written order was missing the prescribing practitioner's signature
- Written order was missing the prescribing practitioner's NPI

Clinical Documentation Issues: Medical Necessity could not be established (37%)

Clinical documentation did not support criteria of LCD L11468 for the following reasons (25%)

- No indication in medical documentation of presence of severe lung disease or hypoxia related symptoms (5%)
- Medical documentation does not demonstrate that beneficiary was tested in a chronic stable state (7%)
- Signature requirements were not met (11%)
- Documentation submitted was illegible (1%)
- Replacement oxygen requirements not met (1%)

Clinical documentation did not support criteria indicated on CMN for the following reasons (12%)

- Documentation of a blood gas study performed during exercise did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy (7%)
- 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%)
- Group 1 criteria of an arterial oxygen saturation at or below 88% not met (2%)
- Medical documentation did not support that beneficiary was tested within 2 days prior to discharge, as indicated on the CMN submitted (1%)
- Documentation did not meet the criteria for oxygen prescribed at greater than 4 LPM (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 10/12/13
Code(s) Billed: E1390, E0431

Documentation received: Patient notes form, written order dated 10/12/13, results of blood gas testing dated 10/12/13, physician progress notes dated 10/12/13, supplier agreement and consent form, proof of delivery dated 10/12/13
Missing: Initial CMN, complete and authenticated copy of the physician progress notes dated 10/12/13

Example 2
DOS 5/28/13
Code(s) Billed: E1390

Documentation received: Initial CMN dated 5/28/13, supplier forms, authenticated hospital discharge note dated 5/28/13 that includes documentation of a qualifying diagnosis, authenticated physician progress notes dated 5/24/13, proof of delivery dated 5/28/13
Missing: Documentation of a physician visit dated within 30 days prior to the initial date of service, documentation of a blood gas study in the medical record to validate the blood gas study results provided on the initial CMN

Example 3
DOS 1/21/14
Code(s) Billed: E1390, E0431

Documentation received: Supplier form, detailed written order dated 1/21/14, physician order form dated 1/20/14, initial CMN dated 1/21/14, authenticated progress note dated 12/10/13 that includes a qualifying diagnosis, authenticated progress note dated 2/11/14, customer agreement form, proof of delivery dated 1/21/14, respiratory equipment orientation checklist
Missing: Detailed written order including the date of receipt, physician progress notes dated within 30 days prior to the initial date of service, documentation of a blood gas study in the medical record dated 1/20/14 to validate the blood gas study results provided on the initial 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.

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.

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768) **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**
- The *DME MAC Jurisdiction A Supplier Manual* - **http://www.medicarenhic.com/dme/supmandownload.aspx**
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.
- CERT Error Articles - Monthly publications - **http://www.medicarenhic.com/dme/dmerccertrec.aspx**
- Physician Letter - Home Oxygen Initial Qualification Testing - **http://www.medicarenhic.com/viewdoc.aspx?id=2667**
- Physician Letter - Face-to-Face and Written Order Requirements for High Cost DME **http://www.medicarenhic.com/viewdoc.aspx?id=2581**
- 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: February 25, 2014, November 27, 2013, August 30, 2013, May 17, 2013, February 08, 2013, October 12, 2012, June 29, 2012, March 02, 2012, November 04, 2011, August 26, 2011, November 05, 2010, and June 09, 2010) **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**

- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390 **http://www.medicarenhic.com/viewdoc.aspx?id=2570**

Widespread Prepayment Probe for HCPCS Code J2260 (Milrinone Lactate Injection) (SPE)

DME MAC A will be initiating a widespread prepayment probe of claims for HCPCS code J2260 (INJECTION, MILRINONE LACTATE, 5 MG).

This review is being initiated due to an increase in billing identified by data analysis.

Per the Local Coverage Determination (LCD) for External Infusion Pumps (L5044) an external infusion pump is covered for use with J2260 for the following indications:

Administration of other drugs if either of the following sets of criteria (1) or (2) are met:

Criteria set 1:
- *Parenteral administration of the drug in the home is reasonable and necessary.*
- *An infusion pump is necessary to safely administer the drug*
- *The drug is administered by a prolonged infusion of at least 8 hours because of proven improved clinical efficacy*
- *The therapeutic regimen is proven or generally accepted to have significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hours*

Criteria set 2:
- *Parenteral administration of the drug in the home is reasonable and necessary*
- *An infusion pump is necessary to safely administer the drug*
- *The drug is administered by intermittent infusion (each episode of infusion lasting less than 8 hours) which does not require the beneficiary to return to the physician's office prior to the beginning of each infusion*
- *Systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians Desk Reference, or the U.S. Pharmacopeia Drug Information*

Coverage for the administration of J2260 using an external infusion pump is limited to the following situations:

Administration of parenteral inotropic therapy, using the drugs dobutamine, milrinone and/or dopamine for beneficiaries with congestive heart failure and depressed cardiac function if a beneficiary meets all of the following criteria:

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. Milrinone - - 0.375-0.750 mcg/kg/min***
   - *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.*

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) 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 are covered as long as the coverage criteria for the pump are met.

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

Documentation should include the following:

1. Physician order for the item. Include both the dispensing order (if applicable) and the detailed written order which include the following elements:
    - Description of the item
    - Beneficiary's name
    - Prescribing Physician's name
    - Date of the order and the start date, if the start date is different from the date of the order
    - Physician signature (if a written order) or supplier signature (if verbal order)

2. 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

3. A DME Information Form (DIF) which has been completed, signed, and dated by the supplier.

4. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item(s) are met. This includes information relating to each of the criteria (D1-D8) defined in the Indications and Limitations of Coverage section. This must include the before and after inotropic drug infusion values defined in D3.

5. Proof of delivery which meets the required criteria as outlined in the External Infusion Pumps LCD.

6. Any other pertinent information that would justify payment for the item(s) provided.

7. Advanced Beneficiary Notice (ABN) if one was obtained, this must be submitted with the above requested documentation.

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

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy article. Suppliers can review the LCD for External Infusion Pumps (L5044) and Policy Article (A19713). Also refer to NHIC, Corp. Bulletin, "*Drugs Used With External Infusion Pumps - Coverage and Billing Reminders*" (**http://www.medicarenhic.com/viewdoc.aspx?id=449**)

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

Provider Services Portal (PSP) Invitation & Same/Similar Announcement for specific A, L & V HCPCS (GEN)

NHIC, Corp. invites you to join the Provider Services Portal (PSP). The PSP offers a **free**, electronic, web-based alternative to contacting our IVR and/or Customer Service Call Center.

PSP offers the following information through lookup transactions:

- Beneficiary Eligibility
- Claim Status
- Provider Remittance
- Same/Similar Equipment History (DME)
- Same/Similar and specific A, L and V codes

Future enhancements that will be coming include: Re-openings and Redeterminations.

With the implementation of specific A L, and V codes, you will no longer need to contact customer service representatives to verify same/similar information for specific codes.

The PSP is available 24/7 except during scheduled maintenance windows. As a PSP participant, office staff will have real-time access to the status of your Medicare claims, skilled nursing facility (SNF) spells, Inpatient hospital spells, hospice periods, deductibles, Medicare Part D, preventative services and Medicare secondary payor (MSP) information.

Suppliers who are not yet signed up for the PSP are missing a great opportunity to be able to easily access patient eligibility, claim status, print a copy of a Remittance, and same/similar information . We encourage all interested suppliers to take advantage of this opportunity to increase efficiency via the use of our free web-based portal.

Questions can be submitted via email to: **nhicpspcommunications@hp.com** or call the PSP Helpdesk at 781-741-3192.

Don't miss this opportunity! Sign up NOW!

http://www.medicarenhic.com/dme/psphome.aspx

New FAX number for Redetermination Requests Resulting from an Overpayment (GEN)

Providers and Suppliers who disagree with an overpayment decision have the right to file an appeal with the Contractor that issued the overpayment decision. Section 1893 (f)(2)(a) of the *Social Security Act* provides limitations on the recoupment of Medicare overpayments. This section provides protection to Providers, Physicians, and Suppliers during the initial stages of the appeal process. (IOM 100-06, Chapter 3, Section 200)
(**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf**).

To assist in identifying these types of appeals more efficiently NHIC, Corp. DME MAC Jurisdiction A has implemented a new FAX number specifically for Redetermination Requests resulting from an Overpayment Request by DME MAC A.

The new FAX number for Overpayment Redetermination Requests is:

781-383-4531

The cover sheet for redetermination requests is located on the CMN and Forms page (**http://www.medicarenhic.com/dme/forms.aspx#form4**). When sending in an appeal request on an overpayment, it is recommended that suppliers include a copy of the letter received notifying them of the overpayment, or a copy of the audit results letter if the overpayment was determined by Medical Review, PSC, ZPIC, RA, or CERT.

Note: *When utilizing the Redetermination Request Form, be sure to check off one of the aforementioned departments listed in the overpayment section of the form.*

More information regarding Redeterminations can be found in the *DME MAC A Supplier Manual* (http://www.medicarenhic.com/dme/supmandownload.aspx).

First 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 January through March 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	97,138	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.401.2400.REF02.070 - This Claim is rejected for invalid information within the Line Item Control Number	78,969	Line Item Control Number must be unique within a single iteration of 2300.CLM01.
X222.121.2010BA.NM109.020 - Invalid Information for a Subscriber's contract/member number	21,877	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.087.2010AA.NM109.050 - Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	20,022	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.	13,345	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	9,124	The service start/from date is greater than the date this claim was received.
X222.351.2400.SV101-3.020 - This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	8,996	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.380.2400.DTP03.090 - Invalid Information within the Date(s) of service	8,515	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.
X222.380.2400.DTP03.070 - Invalid information within the Date(s) of service	8,176	The number of services entered for this line is invalid. Capped rentals can only have one unit of service.
X222.087.2010AA.NM109.030 - Invalid information in the Billing Provider's NPI	8,075	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.

First 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 first 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 January through March 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.	25,769
OA109, N104 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	10,433
CO 182, N56 Procedure modifier was invalid on the date of service	**Item 24D** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	9,909
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.	4,261
CO 16, M79 Missing / incomplete / invalid charge	**Item 24F** - Did not complete or enter the appropriate charge for each listed service (submitted charges zero).	2,729
CO 16, MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	1,677
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.	1,378
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.	1,344
CO 140 Patient health identification number and name do not match.	**Item 1A** - This error is received when the patient's health identification number and name do not match.	1,272
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.	1,216

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!

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 March of 2014 chapters 4, 7, 8, and 10 of the *DME MAC A Supplier Manual* were updated. In April of 2014 chapters 1 and 4 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.

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at **http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html**. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

Updating Supplier Records (GEN)

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information must be reported in writing to the NSC within 30 days after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier must then verify their address with the NSC in writing.

Note: *A request to change your address should not be sent to DME MAC A since we cannot change supplier files.*

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms web site at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html** to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly Bulletins and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

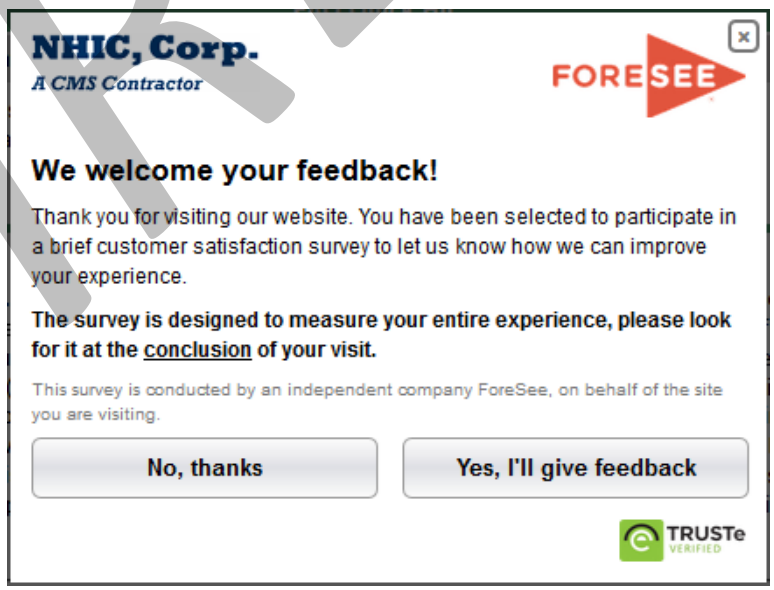
Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at
http://www.medicarenhic.com/dme/listserve.html

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

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

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

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



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


Medicare
Learning
Network®
Official CMS Information for
Medicare Fee-For-Service Providers
http://www.cms.gov/MLNGenInfo

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 print Remittances over the internet. The PSP is currently available for open enrollment. There is no charge to participate!

For more information visit:
http://www.medicarenhic.com/dme/psphome.aspx

Helpful Contacts

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

Outreach & Education

outreach-education@hp.com

Claims Submissions

DME Jurisdiction A Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
Written Inquiry FAX: 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Overpayments

Refund Checks:
NHIC, Corp.
P.O. Box 809252
Chicago, IL 60680-9252

Payment Offset Fax Requests: 781-741-3916

Note: *Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

Redetermination Requests Fax: 781-741-3118

Redetermination Requests 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

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:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:
NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:
Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

DME MAC Jurisdiction A Resource

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

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Publication Information

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

Visit the following websites for more information:

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

TriCenturion: www.tricenturion.com

CMS: www.cms.gov

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

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

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A CMS Contractor

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