DME MAC Jurisdiction A Resource
INFORMATION FOR DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, & VT
March 2014
Number 31

Revised 1500 Claim Form

Effective for claims received on and after April 1, 2014 Medicare will only accept 1500 claim forms submitted on the revised 1500 form version 02/12.

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

Refer to MLN Matters Article MM8509 at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8509.pdf** for additional information.

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

Table of Contents

General Information

Medical Review

Table of Contents

Outreach & Education

Legend

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

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

1099-MISC Form Information (GEN)

NHIC, Corp. will mail all 1099 Forms for calendar year (CY) 2013 on January 31, 2014. Suppliers can expect 1099 Forms to arrive within 7-10 business days from the date of mailing.

NHIC, Corp. will issue a 1099 reflecting payments made on the Jurisdiction A Durable Medical Equipment Medicare Administrative Contract (DME MAC) by TIN from NHIC for CY 2013.

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

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

Common Question/Concerns

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

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

What address will my 1099 be mailed to?

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

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

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

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

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

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

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

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

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

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

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

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

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

2014 Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List (MM8565) (GEN)

MLN Matters® Number: MM8565
Related CR Release Date: January 24, 2014
Related CR Transmittal #: R2861CP

Related Change Request (CR) #: CR 8565
Effective Date: January 1, 2014
Implementation: February 25, 2014

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8565 to notify suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, carrier, or B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor

to be billed for HCPCS codes appearing on the spreadsheet. The spreadsheet for the 2014 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at **http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html** on the CMS website. It is also attached to CR8565

Additional Information

The official instruction, CR 8565 issued to your DME MAC, or A/B MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2861CP.pdf** on the CMS website. The Excel® spreadsheet for the 2014 Jurisdiction List is also attached to CR8565.

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

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

2014 Fees for Repairs/Labor (CR8531) (GEN)

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

The below table identifies the 2014 fee schedule for K0739, L4205, L7520 for dates of service on or after January 01, 2014, through December 31, 2014.

State	K0739	L4205	L7520
CT	24.30	22.16	29.43
DC	14.55	21.66	29.43
DE	26.79	21.66	29.43
MA	24.30	21.66	29.43
MD	14.55	21.66	29.43
ME	24.30	21.66	29.43
NH	15.62	21.66	29.43
NJ	19.63	21.66	29.43
NY	26.79	21.68	29.43
PA	15.62	22.30	29.43
RI	17.34	22.32	29.43
VT	15.62	21.66	29.43

Aprepitant for Chemotherapy Induced Emesis (MM8418) (DRU)

MLN Matters® Number: MM8418
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R180BP, R2883CP, and R163NCD
Related Change Request (CR) #: CR 8418
Effective Date: May 29, 2013
Implementation Date: July 7, 2014

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, J9110);
- 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, J9062);
- Cyclophosphamide (J8530, J9070, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, J9097);
- Dacarbazine (J9130, J9140);
- Mechlorethamine (J9230);
- Streptozocin (J9320);
- Doxorubicin (J9000, J9001, J9002, Q2048, 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 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/R180BP.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/R2883CP.pdf** on the CMS website and the third updates the "*Medicare National Coverage Determinations Manual*" and is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R163NCD.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.

April 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8607) (DRU)

MLN Matters® Number: MM8607
Related CR Release Date: January 24, 2014
Related CR Transmittal #: R2863CP

Related Change Request (CR) #: CR 8607
Effective Date: April 1, 2014
Implementation Date: April 7, 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 MACs (DME MACs) and Home Health & Hospice MACs (HH&H MACs) for services to Medicare beneficiaries.

Provider Action Needed

Medicare will use the April 2014 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 1, 2014, with dates of services from April 1, 2014, through June 30, 2014.

Change Request (CR) 8607, from which this article is taken, instructs Medicare contractors to implement the April 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 January 2014, October 2013, July 2013, and April 2013 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4, section 50 Outpatient PRICER.

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

Files	Effective for Dates of Service
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, 3014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013

Additional Information

The official instruction, CR 8607, issued to your MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2863CP.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.

Calendar Year (CY) 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM8531) (GEN)

MLN Matters® Number: MM8531 Revised
Related CR Release Date: December 13, 2013
Related CR Transmittal #: R2836CP

Related Change Request (CR) #: CR 8531
Effective Date: January 1, 2014
Implementation January 6, 2014

Note: *This article was revised on March 6, 2014, to provide updates regarding HCPCS codes changes that were effective January 1, 2014. The changes are on page 2 (bold). All other information remains unchanged.*

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8531 to advise providers of the Calendar Year (CY) 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and Key Points of CR8531

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

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section1834 (a), (h), and (i) of the *Social Security Act* (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN) and splints, casts, and certain intraocular lenses.

Fee Schedule Files

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

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

The following new codes are effective January 1, 2014;

- A7047 in the inexpensive/routinely purchased (IN) payment category;
- E0766 in the frequently serviced (FS) payment category; and E1352.

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

Factor	Category
0.469	Oxygen
0.472	Capped Rental
0.473	Prosthetics and Orthotics
0.600	Surgical Dressings
0.653	Parental and Enteral Nutrition

Specific Coding and Pricing Issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each; and
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each.

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes,A5512 or A5513. To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of CY2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the Calendar Year 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-Shelf Orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing Off-The-Shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual. Regulations at 42 CFR 414.402 define the term "minimal self-adjustment" to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist,an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient. Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for CY 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "*Medicare Claims Processing Manual*," Chapter 23, Section 60.3.1, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf** on the CMS website.

Prefabricated Orthotic Codes Split into Two Codes - Effective January 1, 2014

Fee from Existing Code	Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes
L0454	L0455 and L0454
L0456	L0457 and L0456
L0466	L0467 and L0466
L0468	L0469 and L0468
L0626	L0641 and L0626
L0627	L0642 and L0627
L0630	L0643 and L0630
L0631	L0648 and L0631
L0633	L0649 and L0633
L0637	L0650 and L0637
L0639	L0651 and L0639
L1810	L1812 and L1810
L1832	L1833 and L1832
L1847	L1848 and L1847
L3807	L3809 and L3807
L3915	L3916 and L3915
L3917	L3918 and L3917
L3923	L3924 and L3923
L3929	L3930 and L3929
L4360	L4361 and L4360
L4386	L4387 and L4386
L4396	L4397 and L4396

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

Neurostimulator Devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable Neurostimulator, Pulse Generator, Any Type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687 and L8688. The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 Implantable Neurostimulator Pulse Generator which was discontinued effective 12/31/2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the *American Taxpayer Relief Act of 2012*, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order Diabetic Testing Supplies (DTS) established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, Change Request (CR) 8204, dated February 22, 2013. You may review the MLN Matters® Articles for these CRs at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf** on the CMS website.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.0 percent for CY 2014. The single payment amount public use file for the national mail order competitive bidding program is available **http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts** on the Internet.

CY2014 Fee Schedule Update Factor

For CY 2014, the update factor of 1.0 percent is applied to the applicable CY 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

2014 Update to the Labor Payment Rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014 and those rates are as follows:

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73	**NC**	14.55	21.68	29.43
AL	14.55	21.68	29.43	**ND**	18.13	31.16	36.73
AR	14.55	21.68	29.43	**NE**	14.55	21.66	41.04
AZ	17.99	21.66	36.21	**NH**	15.62	21.66	29.43
CA	22.32	35.59	41.48	**NJ**	19.63	21.66	29.43
CO	14.55	21.68	29.43	**NM**	14.55	21.68	29.43
CT	24.30	22.16	29.43	**NV**	23.18	21.66	40.12
DC	14.55	21.66	29.43	**NY**	26.79	21.68	29.43
DE	26.79	21.66	29.43	**OH**	14.55	21.66	29.43
FL	14.55	21.68	29.43	**OK**	14.55	21.68	29.43
GA	14.55	21.68	29.43	**OR**	14.55	21.66	42.32
HI	17.99	31.22	36.73	**PA**	15.62	22.30	29.43
IA	14.55	21.66	35.23	**PR**	14.55	21.68	29.43
ID	14.55	21.66	29.43	**RI**	17.34	22.32	29.43
IL	14.55	21.66	29.43	**SC**	$14.55	21.68	29.43
IN	14.55	21.66	29.43	**SD**	16.26	21.66	39.35
KS	14.55	21.66	36.73	**TN**	14.55	21.68	29.43
KY	14.55	27.76	37.64	**TX**	14.55	21.68	29.43
LA	14.55	21.68	29.43	**UT**	14.59	21.66	45.83
MA	24.30	21.66	29.43	**VA**	14.55	21.66	29.43
MD	14.55	21.66	29.43	**VI**	14.55	21.68	29.43
ME	24.30	21.66	29.43	**VT**	15.62	21.66	29.43
MI	14.55	21.66	29.43	**WA**	23.18	31.77	37.74
MN	14.55	21.66	29.43	**WI**	14.55	21.66	29.43
MO	14.55	21.66	29.43	**WV**	14.55	21.66	29.43
MS	14.55	21.68	29.43	**WY**	20.28	28.89	41.04
MT	14.55	21.66	36.73				

2014 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1 percent update factor for the 2014 DMEPOS fee schedule.

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

2014 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in MLN Matters® Articles,MM6792 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf** and MM6990 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf** on the CMS website.

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

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a CY 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR8531 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.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.

Claim Status Category and Claim Status Codes Update (MM8582) (GEN)

MLN Matters® Number: MM8582 Revised
Related CR Release Date: February 24, 2014
Related CR Transmittal #: R2884CP

Related Change Request (CR) #: CR 8582
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: *This article was revised on February 27, 2014, to reflect an updated Change Request (CR). The CR corrects the date when the Claim Status Category Codes and Claim Status Codes will be posted, which is March 1, 2014. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

This article is based on CR 8582 which informs Medicare contractors about 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). 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 January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to 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 CR 8582.

Additional Information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2884CP.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.

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

MLN Matters® Number: MM8509
Related CR Release Date: December 27, 2013
Related CR Transmittal #: R2842CP

Related Change Request (CR) #: CR 8509
Effective Date: January 6, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

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

What You Need to Do

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

Background

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

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

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

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

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

Additional Information

The official instruction, CR 8509 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2842CP.pdf** on the CMS website. CR 8509 contains the instructions for completing the revised CMS 1500 claim form (02/12), which will become part of Chapter 26 in the "*Medicare Claims Processing Manual*" (Pub. 100-04).

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

Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131 (MM8597) (GEN)

MLN Matters® Number: MM8597
Related CR Release Date: February 14, 2014
Related CR Transmittal #: R2878CP

Related Change Request (CR) #: CR 8597
Effective Date: May 15, 2014
Implementation Date: May 15, 2014

Provider Types Affected

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

What You Need to Know

This article, based on Change Request (CR) 8597, provides the removal of language that was erroneously included in CR8404 and in the "*Medicare Claims Processing Manual*," Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

Key Points of CR8597

- With the exception of Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.

- An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is now available for download at **http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html**.

- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the "Additional Information" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your Medical Assistance plan will pay for this care." HHAs may also use the "Additional Information" on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.

- Some States have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. **Note: If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.**

- HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the State's Medicaid directive. If the HHA's State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State

guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the "Additional Information" box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

Additional Information

The official instruction, CR8597, issued to your MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2878CP.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.

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

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

Note: *This article was revised on February 6, 2014, to modify the answer to question J on page 10 (underlined). The article was previously changed on November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the Advance Beneficiary Notice, CARC codes and DME rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same.*

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

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership

System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

What Providers Need to Know

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

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

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

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

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

Background

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

Below are examples of some of these types of claims:

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

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

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)

- Physician Assistants,
- Clinical Nurse Specialists,
- Nurse Practitioners,
- Clinical Psychologists,
- Interns, Residents, and Fellows,
- Certified Nurse Midwives, and
- Clinical Social Workers.

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

CMS would like to highlight the following limitations:

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

Questions and Answers Relating to the Edits

1. What are the ordering and referring edits?

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits were implemented in two phases:

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

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

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

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

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

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

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

N272 Missing/incomplete/invalid other payer attending provider identifier

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

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

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

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

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

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

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

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

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

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

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

Effect of Edits on Providers

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

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

a. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
  - i. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
  - iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

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

- You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
  - i. **For paper applications** - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - ii. **For electronic applications** - complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
  - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
  - iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
  - v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (**http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html**).

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

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

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

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

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

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

- The Ordering Referring Report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report.

f. Make sure your claims are properly completed.

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

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

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

g. What if my claim is denied inappropriately?

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

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

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

i. Are the Phase 2 edits based on date of service or date of claim receipt?

The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?

Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional Guidance

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

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

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

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

Additional Information

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

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

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

Additional Article Updates

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

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

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

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

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

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

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

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

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

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

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's Contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Impact to You

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

What You Need to Know

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

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

What You Need to Do

When you receive notification from your MAC to revalidate:

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

Background

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

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

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

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

- **For providers NOT in PECOS** - the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.
- **For providers in PECOS** - the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your MAC. Contact information may be found at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf** on the CMS website.

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

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

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf** on the CMS website.

Further Information on Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims (SE1344) (GEN)

MLN Matters® Number: SE1344
Related CR Release Date: October 30, 2013
Related CR Transmittal #: 2805

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

Provider Types Affected

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

Provider Action Needed

This article is related to CR 8401, which requires, effective January 1, 2014, the mandatory reporting of a clinical trial identifier 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 identifier 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.

Since the release of CR 8401, the Centers for Medicare & Medicaid Services (CMS) has learned that some physicians, providers, and suppliers do not have the capability at this time to submit the clinical trial identifier number associated with trial-related claims. This article presents those physicians, providers, and suppliers with an alternative means of satisfying the CR 8401 requirements until January 1, 2015. At that time, such providers must fully comply with CR 8401. Make sure that your billing staffs are aware of the requirement and the implementation changes and dates.

Background

CMS understands that implementing CR 8401 by January 1, 2014, would create an undue hardship on a number of its stakeholders. As a result, for physicians, providers, and suppliers who do not have the capacity at this time to report the clinical trials identifier number associated with trial-related claims, CMS is providing an option to submit a generic number in place of the actual National Clinical Trials (NCT) number.

Beginning January 1, 2014, and continuing no later than through December 31, 2014, those above-mentioned physicians, providers, and suppliers may instead report an 8-digit, generic number of 99999999 using the instructions in CR 8401. This will allow trial-related claims to process appropriately if they are prepared according to instructions in CR 8401. Keep in mind that trial-related claims will be returned if they do not contain either the actual clinical trial identifier number or the 8-digit generic number 99999999 - you may not leave those indicated fields blank. That said, CMS encourages those affected by CR 8401 to update their internal claims processing procedures as expeditiously as possible so they can begin reporting the actual clinical trial identifier number as CR 8401 instructs.

NOTE: This in no way precludes those already reporting and/or able to report the actual clinical trial number on clinical trial-related claims from doing so. Beginning January 1, 2015, without further notice, CR 8401 shall be fully implemented.

NOTE: For clarification, the clinical trial identifier number is required for all items/services provided in relation to participation in a clinical trial, clinical study, or registry that may result from coverage with evidence development (CED), the Medicare Clinical Trial Policy, or a CMS-approved investigational device exemption (IDE) study. For IDE trials, both the IDE and the clinical trial identifier number are required. Specifically, include the clinical trial identifier number if: the beneficiary is enrolled in an approved clinical trial; AND, the claim is for the investigational item or service, AND/OR, the costs are related to the investigational item or service, AND/OR, the costs are related to routine care for the condition in the clinical trial.

Additional Information

The official instruction, CR 8401, issued to your MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2805CP.pdf** on the CMS website. The MLN Matters® article related to CR 8401 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf** on the CMS website.

Section 310.1 of the "*Medicare National Coverage Determination (NCD) Manual*" is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.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.

Healthcare Provider Taxonomy Codes (HPTC) Update, April 2014 (MM8611) (GEN)

MLN Matters® Number: MM8611
Related CR Release Date: February 28, 2014
Related CR Transmittal #: R2888CP

Related Change Request (CR) #: CR 8611
Effective Date: April 1, 2014
Implementation Date: July 7, 2014 (Contractors with the capability to do so will implement April 1, 2014)

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8611, from which this article is taken, instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

Background

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

Both the current Accredited Standards Committee (ASC) X-12 837 institutional and professional Technical Report Type 3 (TR3s) require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standard implementation guides state that this information is:

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

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

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. See **http://aspe.hhs.gov/admnsimp/final/txfin00.htm** on the Internet. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

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

CR 8611 implements the NUCC HPTC code set that is effective on April 1, 2014, and instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

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

Additional Information

The official instruction, CR 8611 issued to your carriers, FIs, A/B MACs, RHHIs, HHHs, and DME MACs, regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2888CP.pdf** on the CMS website.

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

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

MLN Matters® Number: SE1249 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on February 10, 2014, to update certain language to reflect the current status of this change (see bolded language on page 2). Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3. All other information is unchanged.*

Provider Types Affected

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

Provider Action Needed

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

What You Need to Know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the Multi-Carrier System (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. **Change Request 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date.** This **will not** affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare Contractor's Interactive Voice Response (IVR) units and/or Internet portals.

Background

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

Key Points

General Information

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

HETS

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

Frequently Asked Questions

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

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

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

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

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

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

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

Additional Information

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

Implementation of Health Insurance Portability & Accountability Act (HIPAA) *Standards and Operating Rules for Health Care Electronic Funds Transfers* (MM8619) (GEN)

MLN Matters® Number: MM8619
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1351OTN
Related Change Request (CR) #: CR 8619
Effective Date: July 1, 2014
Implementation Date: July 7, 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 and Hospice (HH&H) MACs, for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8619, which informs Medicare contractors that Section 1104 of the *Affordable Care Act* mandates the adoption of a standard for the Health Care Electronic Funds Transfers (EFT) HIPAA transaction and operating rules for the Health Care EFT and Remittance Advice Transaction.

The main intent of these standards and operating rules is to assure health plans transmit a trace number that allows providers to re-associate the EFT health care payment with its associate electronic remittance advice. Make sure that your billing staffs are aware of these changes.

Note that CR 8619 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (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 and the TRN Segment 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 CR8619. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of related CR 8629 (see the related article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8629.pdf** can be accommodated by your accounting processes and systems.

Background

The regulation adopting the Health Care EFT standards is available at **https://www.federalregister.gov/articles/2012/01/10/2012-132/administrative-simplification-adoption-of-standards-for-health-care-electronic-funds-transfers-efts** on the Internet.

The regulation adopting the EFT & ERA Operating Rules can be found at **https://www.federalregister.gov/articles/2012/08/10/2012-19557/administrative-simplification-adoption-of-operating-rules-for-health-care-electronic-funds-transfers#h-4** on the Internet.

A new National Automated Clearinghouse Association (NACHA) standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of electronic funds transfers (EFT) used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05"; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. The TRN data segment must contain the following data elements, separated by an asterisk "*".

Example: TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

Element	Element Name	Mandatory or Optional	Data Content
TRN	Re-association Trace Number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace Type Code	M	Trace Type Code is always a "1".
TRN02	Re-association Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

Additional Information

The official instruction, CR 8619, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1351OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your MAC at their toll-free number, which is 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
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1349OTN

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

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (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 Change Request (CR) 8629 which informs MACs that they must comply with NACHA Operating Rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments. The overarching goal of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a "trace number" that facilitates automatic reassociation of the EFT health care payment with its associated remittance advice.

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 and the TRN Segment 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 CR 8629 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.

A new NACHA standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05"; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See "Healthcare EFT Standard Format" in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~ TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

*** data element separator**

The following table explains this example:

Element	Element Name	Mandatory or Optional	Data Content
TRN	Reassociation Trace Number	M	ASC X12 835 segment identifier. This is always "TRN".
TRN01	Trace Type Code	M	Trace Type Code is always a "1".
TRN02	Reassociation Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\".

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**.The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.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.

Implementing Operating Rule (OR)-Phase III ERA Or Dual Delivery of ERA and Paper Remittance (MM8570) (GEN)

MLN Matters® Number: MM8570
Related CR Release Date: February 14, 2014
Related CR Transmittal #: R1345OTN

Related Change Request (CR) #: CR 8570
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

This MLN Matters® Article is intended for providers and 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) 8570 which informs DME MACs about the changes to facilitate compliance with the Coalition for Affordable Quality Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) mandated Operating Rule (OR) 350: Dual Delivery of Electronic Remittance Advice (ERA) and Standard Paper Remittance (SPR) for 31 days after ERA enrollment by trading partners. Make sure your billing staffs are aware of these changes.

Background

Section 1104 of the *Affordable Care Act* requires the Secretary to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of

health information for the purpose of financial and administrative transactions. As a result of CR8570, DME MACs are instructed to deliver both standard paper remittance and electronic remittance advice to a provider/supplier for a minimum of 31 days after the provider's/supplier's ERA enrollment is effective. Also, at the supplier's discretion, DME MACs will allow for paper remittances to not be received, or to be received for a shorter time period, per CORE Rule 350, section 4.3. In addition, the DME MAC will have discretionary authority to grant dual delivery extension, beyond the initial 31 days, if requested by the supplier.

Additional Information

The official instruction, CR 8570 issued to your MAC regarding this change is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1345OTN.pdf** on the Centers for Medicare & Medicaid Services (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
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

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8602 which instructs providers and clearinghouses on how to volunteer to be chosen for ICD-10 End to End testing with Medicare in July 2014. Potential testers must complete the volunteer form on the MAC website by March 24, 2014.

Background

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2014. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with the Centers for Medicare & Medicaid Services (CMS).

Change Request (CR) 8602 will allow for a small subset of Medicare claims submitters to test with MACs and the Common Electronic Data Interchange (CEDI) contractor to demonstrate that CMS systems are ready for the ICD-10 implementation. This additional testing effort will further ensure a successful transition to ICD-10.

To facilitate this testing, CR8602 requires MACs to do the following:

- Conduct a limited end to end testing with submitters in July 2014. Test claims will be submitted July 21-25, 2014.
- Each MAC (and CEDI with assistance from DME MACs) will select 32 submitters to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will select 16 submitters.) Testers will be selected randomly from a list of

volunteers. At least five, but not more than ten of the testers will be a clearinghouse, and submitters should be a mix of provider types.

- By March 7, 2014, the MACs and CEDI will post a volunteer form to their website to collect volunteer information with which to select volunteers. The form will provide information to verify that volunteers are ready to test, meet the requirements to test, and collect needed data about the tester (how they submit claims, what type of claims will be tested, etc.). Volunteers must submit the completed forms to the MACs and CEDI by March 24, 2014.
- By April 14, 2014, the MACs and CEDI (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set);
    - What dates of service may be used for testing;
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
    - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than 5 NPIs and 10 HICNs per submitter);
    - Notice that if more than 50 claims are submitted, they may not be processed;
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
    - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDI (for the DME MACs) will collect information from the selected test volunteers to request the HICNs, NPIs, and Provider Transaction Access Numbers (PTANs) the testers will use during the testing. The forms for this information must be completed and returned to the MAC/CEDI by May 2, 2014. If these forms are not returned by May 2, the tester may lose the opportunity to test.
- CEDI will instruct suppliers to submit claims with ICD-10 codes with Dates of Service (DOS) 10/1/2014 through 10/15/2014. They may also submit claims with ICD-9 codes with DOS before 10/1/2014.
- MACs will instruct testers to submit test claims with ICD-10 codes with DOS on or after 10/1/2014. They may also submit test claims with ICD-9 codes with DOS before 10/1/2014.
- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the Electronic Remittance Advices (ERAs) from testing. MACs and CEDI will provide information to the testers on who to contact for testing questions. There may be separate contacts for front end questions and remittance questions.
- MACs will post an announcement about the testing to their websites.

Additional Information

The official instruction, CR 8602, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1352OTN.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, 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: February 26, 2014
Related CR Transmittal #: R1353OTN
Related Change Request (CR) #: CR 8465
Effective Date: December 3, 2013
Implementation Date: March 3, 2014

Note: *This article was revised on February 27, 2014, to reflect a revised CR that provides additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (page 2 in bold). The transmittal number, CR release date and link to the CR were also changed. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for 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 18, 2014, your contractor will report the following to CMS:
  - Number of trading partners conducting testing during the testing week.
  - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
  - Percent of test claims accepted versus rejected.
  - Report of any significant issues found during testing.

Additional Information

The official instruction, CR8465, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1353OTN.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.

Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492 (SE1408) (GEN)

MLN Matters® Number: SE1408
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 7492
Effective Date: October 1, 2014
Implementation Date: N/A

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2014, entities covered under the *Health Insurance Portability and Accountability Act* (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013 implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2014, implementation date.** Make sure your billing and coding staffs are aware of these changes.

Key Points of SE1408

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to

http://www.cms.gov/Medicare/Coding/ICD10/index.html for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2014. Institutional claims containing ICD-9 codes for services on or after October 1, 2014, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2014, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2014, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2014, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2014, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2014, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2014. Institutional claims containing ICD-10 codes for services prior to October 1, 2014, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2014, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2014, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2014, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2014. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A - Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health - Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2014.	*See Note
34X	Home Health - (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/20143 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A - Always ICD-9 code set.	N/A

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
82X	Hospice - Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM
83X	Hospice - Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2014, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C - Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/14 but end on 10/1/14 are to be billed with ICD-9 diagnosis codes and use 9/30/14 as both the FROM and THROUGH date.	FROM

Table D -Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/14 (i.e., the FROM date of service occurs prior to 10/1/14 and the TO date of service occurs after 10/1/14).	FROM

Additional Information

You may also want to review SE1239 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf** on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014.

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.

Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach (SE1409) (GEN)

MLN Matters® Number: SE1409 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: October 1, 2014
Implementation Date: N/A

Note: *This article was revised on February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing.*

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2014, entities covered under the *Health Insurance Portability and Accountability Act* (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare Fee-For-Service (FFS) provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below

CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for 4weeks;
- Beta testing is performed by a separate Integration Contractor for 8 weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as National Coverage Determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at **http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html** on the CMS website;

- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at **http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html** on the CMS website. On this web page, you can also find current versions of the *ICD-10-CM MS-DRG Grouper, Medicare Code Editor* (available from National Technical Information Service), and *MS-DRG Definitions Manual* that will allow you to analyze any payment

impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

- A pilot version of the October 2013 Integrated Outpatient Code Editor (IOCE) that utilizes ICD-10-CM located at **http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf** on the CMS website. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for Local Coverage Determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

Acknowledgement Testing

CMS will offer ICD-10 acknowledgement testing from March 3-7, 2014. This testing will allow all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

End-to-End Testing

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® 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/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html** on the CMS website.

Medicare System Project for Electronic Submission of Medical Documentation (esMD) (SE1343) (GEN)

MLN Matters® Number: SE1343
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 Special Edition (SE) MLN Matters® Article is intended for all Medicare Fee-For-Service (FFS) providers and suppliers who submit medical documentation to Medicare review contractors.

Provider Action Needed

This article is based on the utilization of the Electronic Submission of Medical Documentation (esMD) via Medicare's esMD Gateway to respond to review contractor's requests for medical documentation.

Background

The Centers for Medicare & Medicaid Services (CMS) uses several types of review contractors to measure, prevent, identify, and correct improper payments or identify potential fraud.

Review contractors find improper payments and potential fraud by reviewing a sample of claims. They request medical documentation from the provider or supplier and manually review the claims against the medical documentation to verify the providers' compliance with Medicare's rules.

As of September 2011, providers are able to respond to these requests for medical documentation electronically using the Electronic Submission of Medical Documentation (esMD) via Medicare's esMD Gateway. Since September 2011, CMS enhanced the esMD Gateway to support several new use cases, for example:

- In September 2012, CMS implemented a Prior Authorization (PA) process via the esMD Gateway for Power Mobility Devices (PMD) for FFS Medicare beneficiaries who reside in seven states with high populations of error prone providers (CA, IL, MI, NY, NC, FL and TX).
- In January 2013, CMS expanded the CMS esMD Gateway to allow Durable Medical Equipment (DME) suppliers and providers to send electronic PA Requests to Medicare review contractors.
- In June 2013, CMS enabled automated Prior Authorization Review Results Responses from Medicare review contractors to Health Information Handlers (HIHs) via the esMD Gateway.

Medicare's esMD system provides an alternative mechanism for submitting medical documentation, PMD PA requests, and PMD result code responses to review contractors. A list of review contractors that will accept esMD transactions, as well as receive PMD PA requests and send PMD PA review results can be found at **http://go.cms.gov/RevCon** on the CMS website.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing paper processing and mailing of medical documentation to review contractors.

The number of participants in the CMS esMD Program has grown steadily since its inception.

As of September 30, 2013:

- **449,460 Unique Medical Record Transactions** have been submitted;
- **30,199 Medicare Providers** are using esMD to respond to medical record requests;
- **55 Medicare Providers** use esMD to submit Prior Authorization Requests;
- **24 HIHs** are certified by CMS to offer esMD services;
- **27 Review Contractors** are approved by CMS to accept medical records via esMD

Medicare providers, including physicians, hospitals, and suppliers must obtain access to a CONNECT-compatible gateway in order to send medical documentation electronically to review contractors.

For example:

- Larger providers, such as hospital chains, may choose to build their own gateway;
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a HIH that offers esMD Gateway services.

HIHs contract with providers to supply them with esMD services much the same way that providers contract with claims clearinghouses to supply them with claims submission services.

A listing of the HIHs that have been approved by CMS to offer esMD services can be found at **http://go.cms.gov/esmd-HIH** on the CMS website.

HIH's set the price of their esMD provider services. Providers are encouraged to contact one or more of the HIHs to determine what esMD services are available.

While esMD is not mandatory, many healthcare providers find that it reduces costs, increases efficiency, and shortens processing times for certain transactions. CMS has instructed review contractors to not target providers for medical review based on their use of esMD.

The esMD system accepts Portable Document Format (PDF) files, which enables providers to use esMD services as long as they have the proper scanning mechanism. Some HIHs may offer scanning services in addition to their esMD services.

Additional Information

If you have any questions, please contact the review contractor to whom you wish to send esMD transactions. The review contractor toll-free numbers can be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

For more information, visit the esMD webpage at **http://www.cms.gov/esmd** on the CMS website, or follow esMD on Twitter @CMSGov (#CMS_esMD).

For more information on the Medicare Recovery Audit program, see the MLN Matters® article SE1024 at **http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf** on the CMS website.

Contact information for your Recovery Auditor is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RAC-Contact-Information-AbbrState-Apr2013.pdf** on the CMS website.

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 Revised
Related CR Release Date: March6, 2014
Related CR Transmittal #: R1356OTN

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

Note: *This article was revised on March 7, 2014, to reflect a revised Change Request (CR). The revise CR changes the effective and implementation dates. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

This article is based on CR 8456, which informs Medicare contractors about changes to the Medicare Beneficiary Database (MBD) File to include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare Secondary Payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers' compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional Information

The official instruction, CR8456 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.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.

Part B Claims Submission under the Indirect Payment Procedure (IPP) (MM8266) (GEN)

MLN Matters® Number: MM8266
Related CR Release Date: January 22, 2014
Related CR Transmittal #: R2860CP

Related Change Request (CR) #: CR 8266
Effective Date: For claims processed on or after January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for entities submitting paper claims under the Indirect Payment Procedure (IPP) to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), for services to Medicare beneficiaries.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 8266, which establishes a process for IPP entities to submit paper claims for qualified Part B expenditures, including physician services, supplier services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

What You Need to Know

This article describes the process established for IPP entities to submit paper claims for qualified Part B expenditures for claims processed on or after January 1, 2014.

- IPP claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including drugs administered via DME, will continue to be processed by the DME MACs.
- IPP claims for other Part B services, including drugs administered incident to a physician service, will continue to be processed by the Part B MACs.

IPP entities are generally required to adhere to standard Medicare policies and procedures that would apply to a physician or other supplier billing for a Part B item or service. Therefore, such IPP entities are expected to know and comply with the relevant Medicare Fee-For-Service policies and procedures, which may be found in the "*CMS Internet Only Manual*" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html** and such applicable updates commonly published by CMS as transmittals, which may be found at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html** on the Centers for Medicare & Medicaid Services (CMS) website.

What You Need to Do

- IPP entities and their billing staffs should be aware that CR8266 directs Medicare contractors to implement the framework needed within the Medicare claims processing system to handle IPP claims.
- You may not begin submitting claims until you are registered and approved to submit IPP claims.
- Watch for a separate CR which will outline the registration process for IPP entities.

Background

The process by which the CMS accepts and processes claims submitted by entities that provide coverage complementary to Medicare Part B is called the Indirect Payment Procedure (IPP). If an entity:

1) meets all of the requirements of the regulation at 42 Code of Federal Regulations (CFR) Section 424.66,
2) is registered as an "IPP entity" in accordance with the instructions in "*Medicare Program Integrity Manual*," Pub. 100-08, Chapter 15, Section 15.7.9 through 15.7.9.7, and
3) submits claims in accordance with the specifications of CR8266,

then Medicare may pay that IPP entity for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier.

Although the IPP differs in many respects from the direct payment process, the most important features of Medicare Part B coverage policy, Fee-For-Service payment policy, Fee-For-Service billing procedures, and related matters adhere to the same Medicare Part B standards to which direct billers are subject. Accordingly, CR8266 focuses mostly on the differences that the IPP requires and on eliminating potential ambiguities that the IPP might generate.

Though CR8266 implements the framework needed within the claims processing system to handle IPP claims, IPP entities may not begin submitting claims until they are registered and approved to submit IPP claims. Implementation of the registration process for IPP entities will be handled in a separate CR.

Medicare Policy for IPP Entities

Because IPP entities do not meet the definition of a "health care provider" (as described in 45 CFR Section 160.103), such entities are not eligible for a National Provider Identifier (NPI). Therefore, in order to facilitate the submission of IPP entities claims, IPP entities must apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID) as specified by 45 CFR Section 162.

For more information on the HPID and the OEID, go to **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html** on the CMS website.

Policies and procedures applicable to claim submission by, and payment to, IPP entities will be different in several aspects from those normally applied to physicians and other suppliers that bill directly for Part B items and services. These IPP-specific policies and procedures follow.

General Policies

1. The IPP is available only to an entity that: (1) meets all of the requirements of the regulation at 42 CFR Section 424.66; (2) is registered as an IPP entity in accordance with the instructions in the "*Medicare Program Integrity Manual*," Chapter 15, Sections 15.7.9 through 15.7.9.7; and (3) submits IPP claims in accordance with the terms of CR8266.

2. An IPP entity that submits claims under the IPP is subject to standard Medicare policies and procedures, including but not limited to Medicare Part B coverage policies, payment policies, billing procedures, and related policies and procedures except as specified in this Transmittal and all other applicable CMS directives.

3. In the event of an actual or perceived conflict between standard Medicare Part B processes and IPP, the specifications of CR8266 and any other IPP-specific CRs that may be issued in the future will govern the IPP.

4. IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. (Section 1842(h)(1) of the *Social Security Act* permits only "physicians and suppliers" to enter into participation agreements; an IPP entity does not meet the definition of a "supplier" as described in 42 CFR section 400.202.) Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95% of the physician fee schedule amount.

5. An IPP entity may choose to file IPP claims for only some items and services, or for some enrollees, or a combination thereof.

Coverage and Payment Policies

1. All payments to IPP entities shall be made in accordance with general Medicare Fee-For-Service coverage and payment policies.

2. No payment shall be made to IPP entities for any item or service that is not covered by Medicare Part B on the Date of Service (DOS).

3. No payment shall be made for any item or service furnished by a physician or other supplier that was not, on the DOS, enrolled in Medicare in the applicable specialty required or permitted for furnishing the item or service.

4. No payment shall be made to an IPP entity for any item or service furnished to an individual who was not entitled to, and enrolled in, Medicare Part B as a beneficiary for the DOS.

5. No payment shall be made to an IPP entity for any item or service if payment is prohibited because a statutory exclusion applies or if payment is otherwise barred under any applicable statutory or regulatory standard.

6. No payment shall be made for any item or service furnished by a "provider", as that term is defined in 42 C.F.R. Section 400.202.

7. No incentive payment shall be made to an IPP entity. Such payments include, but are not necessarily limited to, the following incentive payments: Health Professional Shortage Area (HPSA), Primary Care Incentive Payment (PCIP), HPSA Surgical Incentive Payment (HSIP), e-Prescribing, Physician Quality Reporting Systems (PQRS), and Electronic Health Records (EHR).

8. IPP entities must accept assignment on all IPP claims.

9. Medicare Secondary Payer rules apply. Medicare will not make payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim.

10. Medicare payment can only be made once for a beneficiary's particular service. If an IPP entity submits a claim for a beneficiary's service that has already been billed to and paid by 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 and paid by Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his claim), then Medicare cannot make payment to the physician for that same service.

IPP Billing and Claims Processing Policies

1. Standard claims submission and processing rules will generally apply to IPP billing. The IPP entity must submit claims that conform to Medicare requirements for physicians and other suppliers except as noted in CR8266. Clarifications and exceptions to standard Medicare claims submission and processing rules are noted below.

2. Standard claims filing jurisdiction rules apply to IPP billing. As such, the location of the IPP entity is irrelevant to establishing claims filing jurisdiction.
    a. Claims for most Part B services, including drugs administered incident to a physician service, will generally be processed by MACs. Claims filing jurisdiction for such claims is based on the location where the service was performed, i.e., where the physician or other supplier performed the service.

    b. Claims for most DMEPOS items and supplies, including drugs administered via DME, will generally be processed by the DME MACs. Claims filing jurisdiction for most DMEPOS claims is based on the location where the beneficiary permanently resides. Claims for some items of DME, such as implantable devices, must be submitted to the same MAC to which the surgical service claim was submitted. (Although IPP entities are generally permitted to submit some claims under the IPP but not others, if the IPP entity elects to submit a claim for an implantable device under the IPP, the IPP entity must also submit the related surgical claim. Otherwise, the claim for the implanted device will be denied.) CMS publishes an annual DMEPOS jurisdiction list that indicates the claims filing jurisdiction for items of DMEPOS.

3. Standard claims completion and submission rules generally apply to IPP billing. Exceptions are as follows:
    a. The IPP entity must submit all IPP claims on the paper claim form CMS-1500 until such time as an electronic claims submission process is established for IPP claims. MACs will reject and return-as-unprocessable all IPP claims submitted on any other form or in any other format.

    b. The IPP entity must, on all IPP claims, include its name and address in Item 33 of the CMS-1500.

    c. The IPP entity must include its HPID or OEID in Item 33b of the CMS-1500, preceded by qualifier "XV". For example, if an IPP entity has an OEID of 2222222222, then the value entered in Item 33b should be "XV2222222222".

    d. The IPP entity must annotate its Tax Identification Number (TIN) in Item 25 of the CMS-1500.

    e. The IPP entity must include the NPI of the rendering physician or supplier in Item 24J of the CMS-1500.

    f. The IPP entity must include the name and NPI of the ordering or referring physician in Item 17 of the CMS-1500.

    g. The IPP entity must not submit an IPP claim, except a DMEPOS claim, until it is registered as an IPP entity with the appropriate MAC that has claims filing jurisdiction for the IPP claim. The IPP entity must not submit an IPP DMEPOS claim until it is registered as an IPP entity with the National Supplier Clearinghouse (NSC), at which time the IPP entity may file a DMEPOS claim to the DME MAC having jurisdiction for adjudicating such a claim. Once registered, the IPP entity may file any IPP claim that predates the effective date of its registration as an IPP entity provided the claims meet the timely filing rule specified in 42 CFR Section 424.44.

4. Standard claims processing rules generally apply to IPP billing. The specifications of the business requirements in CR8266 are controlling, but the following are noted for emphasis.
    a. MACs shall reject and return-as-unprocessable an IPP claim that is submitted with missing, incomplete, or invalid information, including but not limited to the information specified in paragraph 3, above.

    b. MACs shall append demonstration code "70" to all IPP claims upon receipt. IPP claims shall be identified by the presence of an HPID or OEID belonging to a registered IPP entity in Item 33b of the CMS-1500 claim form.

Medicare Secondary Payer & Coordination of Benefits

1. Medicare Secondary Payer (MSP) rules apply. Medicare will not make primary payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim. MACs will inform beneficiaries regarding the applicability of MSP to IPP initial determinations via Medicare Summary Notice (MSN) message 29.35.

2. IPP claims are excluded from the National Coordination of Benefits Agreement (COBA) crossover process.

Additional Information

The official instruction, CR8266 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2860CP.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.

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

MLN Matters® Number: MM8506
Related CR Release Date: February 5, 2014
Related CR Transmittal #: R159NCD
Related Change Request (CR) #: CR 8506
Effective Date: October 1, 2014
Implementation: October 1, 2014

Provider Types Affected

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

Provider Action Needed

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

The changes were made to comply with:

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

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

Background

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

Additional Information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R159NCD.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.

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2014 (MM8568) (GEN)

MLN Matters® Number: MM8568
Related CR Release Date: January 10, 2014
Related CR Transmittal #: R2853CP

Related Change Request (CR) #: CR 8568
Effective Date: April 1, 2014
Implementation: April 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) 8568 to provide the DMEPOS CBP April 2014 quarterly update. CR 8568 provides specific instructions for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

Section 302 of the *Medicare Modernization Act of 2003* (MMA) established requirements for a new CBP for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. 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 expires on December 31, 2013. On January 1, 2014, new contracts for the Round One Recompete in the same nine areas take effect. There will also be some changes to the specific DMEPOS items that are part of the program in these areas starting on January 1, 2014.

Additional Information

The official instruction, CR 8568, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2853CP.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.

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

More information about the CBP is also available at **http://www.dmecompetitivebid.com** on the Internet. The information at this site includes information on all rounds of the CBP including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

Recalcitrant Provider Procedures (MM8394) (GEN)

MLN Matters® Number: MM8394
Related CR Release Date: December 13, 2013

Related CR Transmittal #: R495PI

Related Change Request (CR) #: CR 8394
Effective Date: January 15, 2014 - This process is currently in effect and this is a clarification through a manual update.
Implementation Date: January 15, 2014

Provider Types Affected

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

What You Need To Know

The CR that this article refers to how MACs will address recalcitrant providers and suppliers. The Centers for Medicare & Medicaid Services (CMS) has learned from contractors that some providers are abusing the Medicare program and not changing inappropriate behavior even after contractors provide them extensive education to address these behaviors. These noncompliant providers who refuse to comply with CMS rules, result in contractors' placing these providers on prepay medical review and causing an administrative burden.

Background

Over the years, CMS has heard from Medicare contractors that some providers are abusing the Medicare program; and, even after extensive educational efforts, do not change their inappropriate behavior.

Notes: In this context:

1. **Providers** are defined as both providers and suppliers, under their current definitions found in the Code of Federal Regulations (CFR) at 42 CFR, Section 400.202); and

2. **Recalcitrant providers** are defined as those who abuse the Medicare program and do not change their inappropriate behavior even after their Medicare contractors have given them extensive provider education addressing these behaviors.

The behavior of these recalcitrant providers who refuse to comply with CMS requirements has resulted in their being placed on prepay medical review for long periods of time, requiring the extensive use of contractor resources; that (while, indeed, protecting Trust Fund dollars) would be better utilized for other types of more productive oversight activity.

Accordingly, CMS is encouraging contractors to take advantage of current sanctions to address this problem of recalcitrant providers. The two authorities that may be appropriate to impose such a sanction are 1128A (a)(1)(E) of the *Social Security Act* (the Act), or 1128(b)(6)of the Act; which you can find at **http://www.ssa.gov/OP_Home/ssact/title11/1128.htm** on the internet. Both of these sanctions are delegated to the Office of the Inspector General (OIG), who will work with CMS to pursue these cases.

CR 8394, from which this article is taken, updates chapter 4 Section 4.27 of the "*Medicare Program Integrity Manual*" by adding a section formalizing the process for addressing recalcitrant providers and suppliers.

NOTE: *Any provider referred as a potential recalcitrant provider case should be an "outlier," meaning a provider who has been the least receptive to changing and has a significant history of non-compliance. For any case submitted, it is important to remember that different mitigating or aggravating circumstances may need to be applied.*

Additional Information

The official instruction, CR 8394, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R495PI.pdf** on the CMS website. You will find the updated "*Medicare Program Integrity Manual*," Chapter 4 (Benefit Integrity), Section 27 (Recalcitrant Providers) as an attachment to that CR.

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.

Registration of Entities Using the Indirect Payment Procedure (IPP) (SE1406) (GEN)

MLN Matters® Number: SE1406
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 8284
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended for entities that may register for indirect payment of claims submitted to Medicare contractors (A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs)) for services furnished to Medicare beneficiaries.

What You Need to Know

Impact to You

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or other supplier who charges on a Fee-For-Service (FFS) basis may be paid to an entity under the IPP.

What You Need to Know

This SE article outlines the IPP registration process for these entities.

What You Need to Do

Make sure that your billing staffs are aware of the IPP registration process.

Background

Medicare Part B payment otherwise payable to a beneficiary for the services of a physician or other supplier who charges on a Fee-For-Service basis may be paid to an entity under the IPP if the conditions described in 42 CFR § 424.66 are met.

Under 42 CFR § 424.66, Medicare may pay an "IPP entity" (such as an employer, union, insurance company, retirement home, health care prepayment plan, health maintenance organization, competitive medical plan, or Medicare Advantage plan) 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 (this 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 his/her 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, his/her survivors, or estate;

5. Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program; and

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

(You can find 42 CFR § 424.66 at **http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec424-66/content-detail.html**)

As an illustration, suppose an entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims.

It is important to note that an IPP entity is not a Medicare provider or supplier, is not eligible for a National Provider Identifier, and cannot enroll in the Medicare program. Nevertheless, it is crucial that Medicare obtain sufficient background information on prospective IPP entities to help ensure the integrity, accuracy, and legitimacy of Medicare payments. Such entities will therefore be required to complete the IPP registration process described below (and in more detail in CR 8284) before they can submit claims via the IPP. CMS will apply the Form CMS-855 process to IPP entities consistent with CMS' authority to request information under 42 CFR § 424.66.

Contractor Jurisdiction

Claims for all Part B items and services - other than for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - must be submitted to the A/B MAC based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides; however, claims for Medicare-covered implantable devices (although classified as DME) are submitted to the A/B MAC based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to the submission of registration applications.

Registration Process

To register as an IPP entity, you must:

1) Complete and submit:
   a. A paper Form CMS-855B application to each A/B MAC to which you intend to submit claims, and/or
   b. A paper Form CMS-855S application to the National Supplier Clearinghouse (NSC) if you intend to submit claims to a DME MAC.

2) Complete and submit a paper Form CMS-588 (Electronic Funds Transfer (EFT) Agreement) with your Form CMS-855 application.

3) Submit with each Form CMS-855 application an attestation statement signed by an "authorized official" (as that term is defined in 42 CFR § 424.502) certifying that for each claim you submit, all of the requirements of 42 CFR § 424.66 are met. The certification statement on the Form CMS-855 supplements (but does not supplant) the attestation. **An IPP entity is bound by the terms of the Form CMS-855 certification statement to the same extent it is bound by the attestation's terms.**

   (**NOTE:** Since you may be submitting applications in multiple MAC jurisdictions, it is acceptable to submit a photocopy of a signed attestation rather than an originally signed attestation.)

4) Apply for and receive either a Health Plan Identifier (HPID) or an Other Entity Identifier (OEID), furnish it in the appropriate section of the Form CMS-855, and submit actual issuance documentation with each Form CMS-855 application (for example, an issuance notice from the HPID or OEID that includes the number). See CMS' main website at **http://www.cms.hhs.gov** for information on how to obtain a HPID or OEID.

5) You need not:
   a. Submit licensure or certification information
   b. Report medical record storage information
   c. Pay an application fee
   d. Submit a Form CMS-460 (Medicare Participating Physician or Supplier Agreement)
   e. Meet the DMEPOS (i) supplier standards, (ii) accreditation requirements, (iii) surety bond requirements, or (iv) liability insurance requirements

Processing of Registration Applications

Upon receipt of your Form CMS-855 registration application, the Medicare contractor will begin processing it. This includes:
   a. Ensuring that the application is complete

b. Verifying the information on the application
c. Ensuring that the attestation described above is submitted, signed by an authorized official, and contains the required language
d. As needed, asking you for additional or clarifying information to determine whether you are in compliance with the provisions of 42 CFR § 424.66 and all other requirements. It is important that you furnish such information to the Medicare contractor promptly. Failure to do so may result in the rejection of your application.
e. Assigning the appropriate specialty code.

If the Medicare contractor and CMS determine that you meet all requirements, the Medicare contractor will (1) establish an effective date of registration, (2) send you an approval letter via regular mail or e-mail, and (3) assign a Provider Transaction Identification Number (PTAN). Please note that after you are registered as an IPP entity, the Medicare contractor (consistent with 42 CFR § 424.66(a)) may request additional information to confirm your continued compliance with all requirements. Moreover, an IPP entity is required to submit to the Medicare contractor all changes to its Form CMS-855 information in accordance with the terms of its signed Form CMS-855 certification statement.

If the Medicare contractor and CMS determine that you do not meet all requirements, your application will be denied. You will receive a letter outlining (1) the specific reason(s) for the denial and (2) your appeal rights.

Additional Information

Please review CR8284 for more detailed information regarding the registration process. CR8284 is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R502PI.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.

Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) and Medicare Remit Easy Print (MREP) and PC Print Update (MM8561) (GEN)

MLN Matters® Number: MM8561
Related CR Release Date: January 10, 2014
Related CR Transmittal #: R2855CP

Related Change Request (CR) #: CR 8561
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8561 which updates the CARC and RARC lists that are effective on April 1, 2014. CR 8561 also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software by April 7, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print 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 (COBs)).

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, 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 8561 lists only the changes that have been approved since the last code update issued on August 30, 2013 in CR 8422 , Transmittal R2776CP and does not provide a complete list of codes for these two code sets. The MLN Matters® Article corresponding to CR 8422, MM8422, can be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8422.pdf** on the CMS website.

Note: If there is any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR 8422

The following tables list the changes in the CARC database since the last code update CR8422. The full CARC list may be downloaded from the WPC website, available at **http://wpc-edi.com/Reference** on the Internet.

New Codes - CARC

Code	Narrative	Effective Date
257	The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)	11/01/2013
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	11/01/2013
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.	11/01/2013
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	11/01/2013
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)	11/01/2013
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	11/01/2013
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	11/01/2013
P6	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/01/2013
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	11/01/2013

Code	Narrative	Effective Date
P8	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Property and Casualty only.	11/01/2013
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	11/01/2013
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.	11/01/2013
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)	11/01/2013
P12	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/01/2013
P13	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	11/01/2013
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	11/01/2013
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.	11/01/2013
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA	11/01/2013
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only	11/01/2013
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.	11/01/2013
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.	11/01/2013
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	11/01/2013
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013
P22	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013

Code	Narrative	Effective Date
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	11/01/2013

Modified Codes - CARC

Code	Modified Narrative	Effective Date
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	11/01/2013
253	Sequestration - reduction in federal payment	11/01/2013

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	07/01/2014
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF)	07/01/2014
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	07/01/2014
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	07/01/2014
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	07/01/2014
218	Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	07/01/2014
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	07/01/2014
221	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	07/01/2014
230	No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty.	07/01/2014
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	07/01/2014
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	07/01/2014

Code	Current Narrative	Effective Date
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply.	07/01/2014
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	07/01/2014
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	07/01/2014
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	07/01/2014
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	07/01/2014
W6	Referral not authorized by attending physician per regulatory requirement.	07/01/2014
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	07/01/2014
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	07/01/2014
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	07/01/2014
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	07/01/2014

Changes in RARC List since CR 8422

The following are changes in the RARC database since the last code update CR 8422. The full RARC list can be downloaded from the WPC website available at **http://wpc-edi.com/Reference** on the Internet.

New Codes - RARC:

Code	Narrative	Effective Date
N677	Alert: Films/Images will not be returned.	11/1/2013
N678	Missing post-operative images/visual field results.	11/1/2013
N679	Incomplete/Invalid post-operative images/visual field results.	11/1/2013

Code	Narrative	Effective Date
N680	Missing/Incomplete/Invalid date of previous dental extractions.	11/1/2013
N681	Missing/Incomplete/Invalid full arch series.	11/1/2013
N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	11/1/2013
N683	Missing/Incomplete/Invalid prior treatment documentation.	11/1/2013
N684	Payment denied as this is a specialty claim submitted as a general claim.	11/1/2013
N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	11/1/2013
N686	Missing/incomplete/invalid questionnaire needed to complete payment determination.	11/1/2013
N687	Alert - This reversal is due to a retroactive disenrollment. (Note: To be used with claim/service reversal)	11/1/2013
N688	Alert - This reversal is due to a medical or utilization review decision. (Note: To be used with claim/service reversal)	11/1/2013
N689	Alert -This reversal is due to a retroactive rate change. (Note: To be used with claim/service reversal)	11/1/2013
N690	Alert - This reversal is due to a provider submitted appeal. (Note: To be used with claim/service reversal)	11/1/2013
N691	Alert - This reversal is due to a patient submitted appeal. (Note: To be used with claim/service reversal)	11/1/2013
N692	Alert - This reversal is due to an incorrect rate on the initial adjudication (Note: To be used with claim/service reversal)	11/1/2013
N693	Alert - This reversal is due to a cancelation of the claim by the provider.	11/1/2013
N694	Alert - This reversal is due to a resubmission/change to the claim by the provider.	11/1/2013
N695	Alert - This reversal is due to incorrect patient financial responsibility information on the initial adjudication.	11/1/2013
N696	Alert - This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment. (Note: To be used with claim/service reversal)	11/1/2013
N697	Alert - This reversal is due to a payer's retroactive contract incentive program adjustment. (Note: To be used with claim/service reversal)	11/1/2013
N698	Alert - This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage. (Note: To be used with claim/service reversal)	11/1/2013

Modified Codes - RARC

Code	Modified Narrative	Effective Date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	11/01/2013
N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate.	11/01/2013
N178	Missing pre-operative images/visual field results	11/01/2013
N244	Incomplete/Invalid pre-operative images/visual field results.	11/01/2013
N597	Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries.	11/01/2013

Deactivated Codes - RARC

Code	Current Narrative	Effective Date
N365	This procedure code is not payable. It is for reporting/information purposes only.	07/01/2014
N627	Service not payable per managed care contract.	07/01/2014

Code	Current Narrative	Effective Date
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	07/01/2014

Additional Information

The official instruction, CR 8561, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2855CP.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.

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
Related CR Release Date: January 2, 2014
Related CR Transmittal #: R1332OTN
Related Change Request (CR) #: CR 8566
Effective Date: April 1, 2014
Implementation: April 7, 2014

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 and Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries.

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-2013-12-02/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 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 January 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.

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/R1332OTN.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/Monitoring-Programs/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	■		
Canes/Crutches	E0117	Underarm spring assist crutch	■		
Glucose Monitor	E0620	Capillary blood skin piercing device laser	■		
High Frequency Chest Wall Oscillation Device (HFCWO)	A7025	Replace chest compress vest	■		
Hospital Beds/Accessories	E0300	Enclosed ped crib hosp grade	■		
Misc. DMEPOS	A4639	Infrared ht sys replacement pad	■		
	E0762	Trans elec jt stim dev sys	■		
	E1700	Jaw motion rehab system	■		
Nebulizers & Related Drugs	K0730	Ctrl dose inh drug deliv system	■		
Other Neuromuscular Stimulators	E0740	Incontinence treatment system	■		
	E0764	Functional neuromuscular stimulation	■		
Pneumatic Compression Device	E0656	Segmental pneumatic trunk	■		
	E0657	Segmental pneumatic chest	■		
Power Operated Vehicles	E0984	Add pwr tiller	■		
Speech Generating Devices	E2500	SGD digitized pre-rec <=8min	■		
	E2502	SGD prerec msg >8min <=20min	■		
	E2504	SGD prerec msg>20min <=40min	■		
	E2506	SGD prerec msg > 40 min	■		
	E2508	SGD spelling phys contact	■		
	E2510	SGD w multi methods messg/access	■		
Support Surfaces	E0197 *	Air pressure pad for mattress		■	■
	E0198	Water pressure pad for mattress	■		
Traction Equipment	E0849	Cervical pneum traction equip	■		
	E0855	Cervical traction equipment	■		

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
	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	■		

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
	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	■		
	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

Revised Beneficiary Liability and Messages Associated with Denials for Claims for Services Furnished to Incarcerated Beneficiaries (MM8488) (GEN)

MLN Matters® Number: MM8488 Revised
Related CR Release Date: December 27, 2013
Related CR Transmittal #: R1330OTN

Related Change Request (CR) #: CR 8488
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: *This article was revised on January 15, 2014, to reflect the revised CR8488 issued on December 27, 2013. In the article, the effective and implementation dates are changed and the CARC and RARC descriptions are changed to reflect the revised CR8488 descriptions. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised.*

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administration Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries while they are in Federal, State, or local custody.

Provider Action Needed

This article is based on Change Request (CR) 8488 which instructs Medicare Claims Administration Contractors to use an updated Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Group Code when denying claims for services furnished to incarcerated Medicare beneficiaries. See the Background and Additional Information Sections of this article for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

According to Federal regulations at 42 CFR 411.4, Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service, and no other person or organization has a legal obligation to provide or pay for the service. Refer to the Electronic Code of Federal Regulations (e-CFR) at
http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=1270613eb7cae1ed8c62899034b0eca2&rgn=div8&view=text&node=42:2.0.1.2.11.1.35.3&idno=42
on the Internet. This exclusion presumptively applies to individuals who are incarcerated.

Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency. Also, under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare, the claims are rejected by the Common Working File (CWF) and denied by the claims processing contractors. Per previously issued instructions (most recently, CR7678, Transmittal 1054, issued 3/7/2012; see related MLN Matters® article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7678.pdf**),
MACs use the following remittance advice messages and Group Code when denying such claims:

- **Claim Adjustment Reason Code (CARC): 96** - "Non-covered charges."
- **Remittance Advice Remark Code (RARC): N103** - "Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt."
- **Group Code: PR** - Patient Responsibility.

CR8488 revises the remittance advice messages and group code used for denials of claims for services furnished to incarcerated beneficiaries.

MACs will begin using the following new CARC code when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody:

- **CARC: 258** - Claim/service is not covered when patient is in custody/ incarcerated. Applicable federal, state or local authority may cover this claim/service.

In addition, MACs will begin using the following revised RARC N103 language when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody:

- **RARC: N103** - "Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/Local authority as appropriate."

MACs will begin using the following Group Code to assign proper liability when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody so that the provider or supplier should seek repayment for the cost of its services provided from the authority that was in custody of the beneficiary on the date of service:

- **Group Code: OA** - Other Adjustment

Other than the above, MACs will continue to use existing Remittance Advice codes and messages and MSN language already in place when denying claims for services furnished to beneficiaries while they are in Federal, State, or local custody.

Additional Information

The official instruction, CR8488 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1330OTN.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.

Updated Mobile Applications (Apps) for Open Payments (SE1402) (GEN)

MLN Matters® Number: SE1402
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation: NA

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to alert the provider community of updates to the mobile applications (apps), *Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*, implemented as a result of user feedback to CMS. See the Background and Key Points sections of this article for details.

Also, a part of SE1402 is new technical documentation: "The Open Payments QR Code Reader How-To Guide." Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

Background

In July 2013, CMS released two mobile apps: *Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*. Below are enhancements to the original Open Payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the Welcome screen;
- Adding the ability to export all profile data associated with a payment into CSV format; and
- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: **http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html** on the CMS website. For help with the apps contact the CMS helpdesk at **OpenPayments@cms.hhs.gov**

Key Points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the Google Play™ app store or iOSApple™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for Open Payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

Changes that Apply to Both Apps
(*Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*)

Enhancement Topic	Details - What It Does
Streamlined "Welcome" screen options	• A number of infrequently used menu options (e.g., "Program Information" and "Change Password") moved from the "Welcome" screen and now appear in a hidden menu. • To access the menu, swipe to the right at the "Welcome" screen.
Reports/Statistics	• A new "Reports/Statistics" button, accessible on the "Welcome" screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within *Open Payments Mobile for Industry*) or vendor (within *Open Payments Mobile for Physicians*). • This new chart creation capability will streamline data review.
CSV exporting	• When payment data is exported via CSV format, all profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.). • The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process.
Streamlined "Add Payment" process	• The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the "Add Payment" menu. • The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the "Add Payment" menu.
Easy payment duplication	• A new button available on the "View Payment" screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment. • The only data field that needs to be re-entered is the date.
Vendors/Physicians sorted alphabetically	• In "Manage Vendors/Physicians," vendors or physicians are now listed alphabetically. • The prior app version listed vendors and physicians in the order in which they were entered.
Email/print QR code added	• A "Share" button is available to email or print a QR code that is generated within the app, for sharing at a later time.

Enhancement Topic	Details - What It Does
Payment QR code warning added	• After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code.
Additional data elements added in "Add Payment" > "Travel & Lodging"	• When nature of payment in "Add Payment" is "Travel & Lodging," the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it).
Tablet support	• Both apps are optimized for viewing on tablet devices.

Changes that Apply to Just One App
Open Payments Mobile for Physicians

Enhancement Topic	Details - What It Does
"Manage Companies" added	• Within "Manage Vendors", a new data field allows users to assign vendors to companies when entering new vendor information. • Company information is needed for the "Reports/Statistics" functionality to illustrate all payments by company name.

The updated **Frequently Asked Questions** about the mobile apps contain all the details about these enhancements (link to the document above, or visit the "Apps for Tracking Assistance" page on the Open Payments website).

QR Code Technical Guide Available for Apps: Also now available to support use of the Open Payments apps is a how-to-guide that explains the technical details associated with how to create Quick Response (QR) codes usable in the apps. "The Open Payments QR Code Reader How-To Guide" includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user's devices.

Additional Information

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

To review "*The Open Payments Mobile Application Quick Response (QR) Code Reader Documentation: A How-To Guide to Create Java Script Object Notation (JSON) QR Code*" referenced in this SE1402, see **http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-QR-Code-Reader-How-To-Guide-%5bDecember-2013%5d.pdf** on the CMS website.

To review the series of SE articles leading up to SE1402 see the following:

1. MLN Matters® SE1303 "*Information on the National Physician Payment Transparency Program: Open Payments*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf** on the CMS website.

2. MLN Matters® SE1329 "*Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)*" is available at: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf** on the CMS website.

3. MLN Matters® SE1330 "*Open Payments: An Overview for Physicians and Teaching Hospitals*" may be found at: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1330.pdf** on the CMS website.

Fee Schedule Updates (GEN)

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

- 1st Quarter 2014 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2014 Oral Anticancer Drug Fees
- 3rd Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File

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

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

CMS News Flash (GEN)

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

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

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

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

NEW products from the Medicare Learning Network® (MLN)

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

- "*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**

- "*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**

- "*Hospice Related Services - Part B*" Podcast, ICN 908995, downloadable only **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908995-podcast.html**

REVISED products from the Medicare Learning Network® (MLN)

- "*The DMEPOS Competitive Bidding Program: Traveling Beneficiary*", Fact Sheet, ICN 904484, downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Travel_Bene_Factsheet_ICN904484.pdf**

- "*The DMEPOS Competitive Bidding Program: Referral Agents*," Fact Sheet, ICN 900927, downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Ref_Agt_Factsheet_ICN900927.pdf**

- "*The DMEPOS Competitive Bidding Program: Enteral Nutrition*," Fact Sheet, ICN 901005, downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Enteral_Factsheet_ICN901005.pdf**

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

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

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

- "*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**

- "*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**

REMINDER product from the Medicare Learning Network® (MLN)

- "*Medicare Coverage of Imaging Services*" fact sheet, ICN 907164, downloadable **http://qrs.ly/he3os12**

Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on *ICD-10 Coding Basics* (**http://youtu.be/kCV6aFlA-Sc**), Sue Bowman from the American Health Information Management Association (AHIMA) provides a basic introduction to ICD-10 coding, including:

- Similarities and differences;
- ICD-10 code structure; and
- Coding process and examples.

To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, **subscribe** (**https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819**) to the weekly MLN Connects™ Provider eNews.

In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the "***mailing list for referral agents***" (**https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814**) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

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.

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

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.

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

MLN Connects™ Provider e-News (GEN)

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

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

MLN Connects™ National Provider Calls

- 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 - Last Chance to Register

- Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius - Last Chance to Register
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule - Register Now
- Did You Miss This MLN Connects Call?

CMS Events

- ICD-10 Training Webinar Video: Navigating ICD-10, the Provider Perspective

Announcements

- CMS Updates EFT Authorization Agreement: CMS 588
- Physician Compare: 2012 GPRO Measures Preview Period
- Password Reset in the I&A System
- New QIO Program RFPs Posted
- Ordering and Referring Denial Edits Will Be Implemented on January 6
- New Proposed EHR Meaningful Use Timeline
- Important EHR Payment Adjustment Information for Medicare EPs
- EHR Incentive Programs: Learn How to Conduct a Security Risk Analysis for Your Practice

MLN Educational Products Update

- Winter 2013 Version of Medicare Learning Network Catalog Now Available
- "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius" MLN Matters® Article - Released
- "Further Details on the Revalidation of Provider Enrollment Information" MLN Matters® Article - Revised
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet - Revised
- "The DMEPOS Competitive Bidding Program: Non-Contract Supplier" Fact Sheet - Revised
- "Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record" Fact Sheet - Reminder
- "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information" Fact Sheet - Reminder

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

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-19-Enews.pdf

MLN Connects™ National Provider Calls

- 2-Midnight Benchmark for Inpatient Hospital Admissions - Registration Now Open
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule - Register Now
- 2012 Quality and Resource Use Reports Overview and December Addendum - Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes - Registration Now Open
- Did You Miss This MLN Connects Call?

Announcements

- Remember To Ask, Have You Gotten Your Flu Shot?
- DMEPOS Competitive Bidding Program: January 1, 2014 Round 1 Recompete Implementation - Resources
- Step-by-Step Instructions for Using the I&A System to Access PECOS, EHR, and NPPES
- HHS Announces *Affordable Care Act* Mental Health Services Funding
- More Than 25 Million Original Medicare Beneficiaries Received Free Preventive Services through November 2013
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines
- Upcoming Deadline for EPs in EHR Incentive Programs; Prepare for Attestation
- Request an Informal Review of 2014 eRx Payment Adjustment

Claims, Pricers, and Codes

- CMS Furnishes Final List of Off-The-Shelf Orthotic HCPCS Codes

MLN Educational Products Update

- "Mental Health Services" Booklet - Revised
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet - Reminder

MLN Connects ™ Provider e-News Special Edition for Monday, December 30, 2013

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-30-eNews-SE-PDF.pdf

Announcements

- Verifying Patient Coverage in a Health Insurance Marketplace Plan

MLN Connects™ National Provider Calls

- 2-Midnight Benchmark for Inpatient Hospital Admissions - Register Now
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule - Register Now
- 2012 Quality and Resource Use Reports Overview and December Addendum - CE Credit Available - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now

MLN Connects™ Provider e-News for Thursday, January 09, 2014

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-09enews.pdf

MLN Connects™ National Provider Calls

- 2-Midnight Benchmark for Inpatient Hospital Admissions - Register Now
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule - Register Now
- 2012 Quality and Resource Use Reports Overview and December Addendum - CE Credit Available
- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Did You Miss This MLN Connects Call?
- Transcript and Audio Now Available for December 19 Call on "Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to Jimmo v. Sebelius"

CMS Events

- Join the Next eHealth Provider Webinar to Learn How You Can Prepare for Stage 2
- Hospice Item Set Data Collection Training - Registration Now Available
- Register for ICD-10 Testing Week: March 3-7

Announcements

- January is National Glaucoma Awareness Month
- Continue Seasonal Flu Vaccination through January and Beyond
- More Partnerships between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries
- Exception to the Physician Self-Referral Law for the Donation of Electronic Health Records Items and Services
- Emergency Preparedness Standards for Medicare and Medicaid Participating Providers and Suppliers
- Hospice Quality Reporting Program Data Entry and Submission Site Now Available for FY 2015 Reporting Cycle
- Password Reset in the I&A System
- Learn About 2014 Physician Fee Schedule Rule Changes Affecting eHealth Programs Next Year
- Additional Guidance: How the Proposed New Timeline for the EHR Incentive Programs Affects You
- New Interactive Tool from CMS Helps You Determine Eligibility for eHealth Programs
- Review Your 2013 PQRS Interim Claims Feedback Data
- Didn't Participate in eRx in 2012 or 2013?

Claims, Pricers, and Codes

- CAH Method II Overpayments Related to the Annual Wellness Visit
- Changes to Payment Dispute Process between Non-Contracted Providers, MAOs, and Other Payers after January 31

MLN Educational Products Update

- "Updated Mobile Applications (Apps) for Open Payments" MLN Matters® Article - Released
- "Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments" MLN Matters® Article - Released
- "Further Information on Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims" MLN Matters® Article - Released
- "Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)" MLN Matters® Article - Released
- "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 2]" Educational Tool - Released
- "Information on the National Physician Payment Transparency Program: Open Payments" Podcast - Released
- "Hospice Related Services - Part B" Podcast - Released
- "Discharge Planning" Booklet - Revised
- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet - Reminder
- New MLN Provider Compliance Fast Fact
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, January 16, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-16-enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Providers and Suppliers - Browse the MLN Connects™ Call Program Collection of Resources

MLN Connects™ Videos

- ICD-10 Coding Basics
- CMS Events
- Hospice Open Door Forum

Announcements

- Connections in the I&A System
- CMS to Release a Comparative Billing Report on PAP Devices and Accessories in January
- CMS Quality Strategy - Response Period Extended to January 24
- Review the 2014 PQRS Measures Codes Resources for Claims and Registry-Based Reporting
- Medicare EPs Must Attest by February 28 to Receive 2013 Incentive for EHR Incentive Program

Claims, Pricers, and Codes

- Processing Repair Claims for Capped Rental DME Furnished by the Scooter Store Related Suppliers
- Temporary Hold of Home Health LUPA Claims
- Quarterly Provider Specific Files for the Prospective Payment System Now Available
- January 2014 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products

- "Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-to-Face Encounter"

MLN Matters® Article - Released

- MLN Products Now Available in Hard Copy Format
- Medicare Learning Network® Pilot Testers and Product Reviewers Needed
- Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects™ Provider e-News for Thursday, January 23, 2014

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-23-enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Need to Learn More About ICD-10? The MLN Connects™ Collection of Resources Can Help

CMS Events

- Comparative Billing Report Teleconference

Announcements

- Continue Seasonal Flu Vaccination through January and Beyond
- Submit Quality Data for 2013 PQRS-Medicare EHR Incentive Pilot by February 28

Claims, Pricers, and Codes

- Revised CMS 1500 Paper Claim Form: Version 02/12

MLN Educational Products

- "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet - Revised

MLN Connects™ Provider e-News for Thursday, January 30, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-30eNews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- Previous MLN Connects™ Calls on the National Partnership to Improve Dementia Care in Nursing Homes
- Did You Miss These MLN Connects™ Calls?

CMS Events

- Special Open Door Forum: Final Rule CMS-1599-F
- Hospice Item Set Manual and Data Collection Training Slides Now Available

Announcements

- QCDR Self-Nominations for 2014 PQRS Program Year Accepted Through January 31
- 2014 is the Last Year EPs Can Earn a PQRS Incentive Payment

MLN Educational Products

- "Probe & Educate Medical Review Strategy: Probe Reviews of Inpatient Hospital Claims and Corresponding Provider Outreach and Education" MLN Matters® Article - Released
- "Registration of Entities Using the Indirect Payment Procedure (IPP)" MLN Matters® Article - Released
- "Mass Immunizers and Roster Billing" Fact Sheet - Revised
- New MLN Provider Compliance Fast Fact
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider e-News for Thursday, February 06, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-06-eNews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification - Registration Opening Soon

CMS Events

- eHealth Summit: Road to ICD-10
- Physician Compare Town Hall Meeting
- Webinar for Comparative Billing Report on Upper Limb Orthotics

Announcements

- Medicare Heart Healthy Preventive Services
- Flu Activity is Widespread - Continue to Recommend and Offer Flu Vaccination
- Medicare's Delivery System Reform Initiatives Achieve Significant Savings and Quality Improvements - Off to a Strong Start
- HHS Strengthens Patients' Right to Access Lab Test Reports
- NPPES Modernization - We Need Your Feedback
- New Feature: Simple Online Reset of User IDs and Passwords for PECOS, NPPES, and EHR
- 2013 was Final Program Year for Medicare eRx Incentive Program
- CMS to Release a Comparative Billing Report on Upper Limb Orthotics in February
- Submit Quality Data for 2013 PQRS-Medicare EHR Incentive Pilot by February 28
- Learn What's New in 2014 for PQRS Participation
- New EHR Data Brief Takes a Closer Look at EHR Participation
- EHR Incentive Program: Important Payment Adjustment Information for Medicare EPs

Claims, Pricers, and Codes

- Notification Regarding the New Benefits Coordination & Recovery Center
- Claims Hold for ESRD Facilities that Waived Full PPS Payment
- HIPAA 837 Institutional COB Claims Not Crossing Over Due to Error H24391

MLN Educational Products

- "Psychiatry and Psychotherapy Services" MLN Matters® Article - Released
- "Guidance on Hospital Inpatient Admission Decisions" Podcast - Released
- "Post-Acute Care Transfer-Underpayments" Podcast - Released
- The "Diagnosis Coding: Using the ICD-9-CM" Web-Based Training Course - Revised
- "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" Booklet - Revised
- Updated MLN Matters® Search Indices
- MLN Product Available in Electronic Publication Format
- New MLN Educational Web Guides Fast Fact

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

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-13Enews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Register Now
- 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification - Registration Now Open

CMS Events

- Physician Compare Town Hall Meeting

Announcements

- Increasing Transparency in Health Care with Open Payments
- Teaching Hospital Closures: Rounds 4 and 5 of Section 5506 of the Affordable Care Act
- Extension of Expiring Passwords in the I&A System
- Next PEPPER Release for SNFs, Hospices, LTCHs, Free-Standing IPFs, IRFs, and PHPs to be Available Electronically
- Submit Suggestions for Advanced Diagnostic Imaging Program
- Help Your Patients Navigate the Health Insurance Marketplace

- New EHR Attestation Deadline for Eligible Professionals: March 31
- EHR Incentive Programs: New CMS and ONC Tool Enables Providers to Meet Transitions of Care Measure
- ICD-10 in 2014

Claims, Pricers, and Codes

- Hold for Hospice Claims Containing a Service Facility NPI
- Reprocessing of Air Ambulance Claims
- CY 2014 HH PPS Mainframe Pricer Software Now Available

MLN Educational Products

- Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492" MLN Matters® Article - Released
- "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article - Revised
- "Critical Access Hospital" Fact Sheet - Revised
- Order and Download the Latest MLN Educational Products from the MLN Product Ordering System
- "Guidance on Hospital Inpatient Admission Decisions" Podcast - Rescinded

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

http://go.usa.gov/Bfxh

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Last Chance to Register
- 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification - Last Chance to Register

Announcements

- Flu Activity is Widespread - Continue to Recommend and Offer Flu Vaccination
- CMS to Release a Comparative Billing Report on Nebulizer Drugs in March
- Use New PQRS Interactive Timeline to Prepare for Upcoming Milestones

Claims, Pricers, and Codes

- Hospitals Should Hold Certain A/B Rebilling Outpatient Claims

MLN Educational Products

- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article - Released
- "HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" MLN Matters® Article - Revised
- "Hospice Payment System" Fact Sheet - Revised
- "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet - Revised
- "Sole Community Hospital" Fact Sheet - Revised
- Updated MLN Matters® Search Indices

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

http://go.usa.gov/BJwz

MLN Connects™ National Provider Calls

- PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 - Registration Opening Soon
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Registration Opening Soon

CMS Events

- Register for ICD-10 Testing Week: March 3-7
- ICD-10 Coordination and Maintenance Committee Meeting
- Webinar for Comparative Billing Report on Nebulizer Drugs

Announcements

- Quality Data Added to Physician Compare Website
- Next Edition of Electronic Health Record Technology Certification Criteria Issued
- Adult Immunization: Are You Meeting the Standards for Patient Care?
- Open Payments: Additional Phase 1 Registration and Data Submission Resources Now Available
- Important Information about Upcoming HQRP Reporting Cycle Deadlines
- Deadline for Physician-owned Hospitals to Report Ownership and Investment Information Extended to March 1
- Submit Suggestions for Advanced Diagnostic Imaging Program
- 2013 Final Program Year for the Medicare eRx Incentive Program
- Prepare for Upcoming eHealth Milestones with New eHealth Interactive Timeline
- New and Updated FAQs for the EHR Incentive Programs Now Available

Claims, Pricers, and Codes

- FY 2014 Inpatient PPS PC Pricer Updated with New Provider Data

MLN Educational Products

- "Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014" MLN Matters® Article - Released
- "Basic Medicare Information for Providers and Suppliers" Guide - Revised
- "Medicare Disproportionate Share Hospital" Fact Sheet - Revised
- "Acute Care and the IPPS" Web-Based Training Course - Revised
- New MLN Educational Web Guides Fast Fact
- New MLN Provider Compliance Fast Fact

MLN Connects™ Provider e-News for Thursday, March 06, 2014

http://go.usa.gov/KgZY

MLN Connects™ National Provider Calls

- PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 - Registration Now Open
- Standardized Readmission Ratio for Dialysis Facilities: National Dry Run - Registration Now Open

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting

Announcements

- Help Your Medicare Patients "Enjoy the Taste of Eating Right" During National Nutrition Month® and Beyond
- The Flu Season Is Not Over: It's Not Too Late to Get a Flu Vaccine
- HQRP Deadline: FY 2015 Reporting Cycle Data due April 1
- ICD-10 eHealth University Resources

Claims, Pricers, and Codes

- April 2014 Average Sales Price Files Now Available

MLN Educational Products

- "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies" MLN Matters® Article - Released
- 2014 Medicare Part C and Part D Reporting Requirements for Data Validation WBT - Released

- "Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014" MLN Matters® Article - Revised
- "The DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet - Revised
- "The DMEPOS Competitive Bidding Program: Hospitals That Are Not Contract Suppliers" Fact Sheet - Revised
- "Ambulance Fee Schedule" Fact Sheet - Revised
- "End-Stage Renal Disease Prospective Payment System" Fact Sheet - Revised
- "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet - Revised
- "Quick Reference Information: Home Health Services" Educational Tool - Revised
- "Quick Reference Information: Preventive Services" Educational Tool - Revised

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

DME MAC Jurisdiction A Local Coverage Determinations

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

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

LCD Revision Summary for December 19, 2013 (SPE)

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

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

LCD

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Titration PSG language and qualifying patients for oxygen therapy

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

Policy Article Revision Summary for January 30, 2014 (SPE)

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

Tracheostomy Care Supplies

Policy Article

Revision Effective Date: 03/01/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES and CODING GUIDELINES:

Added: AU modifier usage for A5120 (wipes or swabs) in the same manner as is used for A4450 & A4452

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

LCD and Policy Article Revisions Summary for February 13, 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.

Intravenous Immune Globulin

LCD

Revision Effective Date: 01/01/2014

HCPCS CODES:

Added: J1556

Suction Pumps

LCD

Revision Effective Date: 01/01/2014

COVERAGE, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: A7047 denial statement

HCPCS CODES AND MODIFIERS:

Added: A7047

Revised: A9272 narrative

ICD-9 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:

Added: Code for E0600, A7002 and A7047

DOCUMENTATION REQUIREMENTS:

Added: ICD-9 requirement for E0600, A7002 and A7047

Policy Article

Revision Effective Date: 01/01/2014

CODING GUIDELINES:

Revised: Definition of E0600 to include respiratory suction devices other than those designed to remove secretions

Added: A7047

Revised: A9272 definition to include items previously coded as A9270

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

LCD and Policy Article Revisions Summary for February 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.

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Section V. A to specify vincristine coverage is only for the non-liposomal form of the drug

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

DOCUMENTATION REQUIREMENTS:

Added: ACA 6407 information (requirements effective 07/01/2013)

Policy Article

Revision Effective Date: 07/01/13

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements

Ostomy Supplies

LCD

Revision History Effective Date: 01/01/2014

HCPCS CODES AND MODIFIERS:

Revised: A5081 narrative description

Pressure Reducing Support Surfaces - Group 3

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

Policy Article

Revision Effective Date: 07/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements

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 6, 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.

Automatic External Defibrillators

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

Policy Article

Revision Effective Date: 07/01/2013

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: ACA 6407 requirements

Hospital Beds and Accessories

LCD

Revision Effective Date: 08/01/2013 (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: 07/01/2013
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: ACA 6407 requirements

Manual Wheelchair Bases

LCD

Revision Effective Date: 10/1/2013 (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 information (requirements effective 07/01/2013)

Mechanical In-exsufflation 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

Osteogenesis Stimulators

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

Policy Article

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

Patient Lifts

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

Speech Generating 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

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.*

Draft LCD Cover Letter - Tumor Treatment Field Therapy and Vacuum Erection Devices (SPE)

Dear Physician, Supplier, Specialty Group:

The Centers for Medicare and Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for the purpose of processing and reviewing Medicare claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). The DME MACs are proposing two new draft LCDs: Vacuum Erection Device and Tumor Treatment Fields Therapy.

Summaries of the new LCDs are included below. Copies of the draft policy may be found on each DME MAC web site at:

Jurisdiction A - **http://www.medicarenhic.com**
Jurisdiction B - **http://www.ngsmedicare.com**
Jurisdiction C - **http://www.cgsmedicare.com/jc**
Jurisdiction D - **http://www.noridianmedicare.com/dme**

Each LCD should be completely reviewed prior to the preparation of comments.

Vacuum Erection Devices (VED)

- Propose criteria related to the coverage of these items under the Prosthetic Devices benefit category
- Detail coding and documentation requirements to support the Medicare reimbursement.
- Require Pricing, Data, Analysis and Coding (PDAC) contractor coding verification of VED prior to assignment to L7900 code.

Tumor Treatment Fields Therapy (TTFT)

- Proposes to deny claims for TTFT as not reasonable and necessary
- Provides coding information for TTFT devices

We are soliciting comments on these draft policies from physicians, manufacturers, suppliers and other professionals involved in the ordering of provision of these items. We recommend that you distribute these draft policies to selected members of your organization for review comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy.

If you are providing comments on more than one LCD, please provide separate comments for each policy with the policy indicated in the subject line of the submission.

All comments will be collected at a single point of contact. Please submit your comments electronically to the DME MAC medical director at the e-mail address below no later than COB February 10, 2014. Comments may also be submitted hardcopy although e-mail is preferred.

Address: Robert D. Hoover, MD, MPH, FACP
CGS
2 Vantage Way
Nashville, TN 37228

E-mail: policycomments@cgsadmin.com

A joint DME MAC public meeting will be held on January 14, 2014 from 12:00 p.m. EST until 2:00 p.m. EST at the Grady Memorial Hospital Trauma Auditorium, 80 Jesse Hill Drive SE, Atlanta, GA 30303. Interested parties from any DME MAC jurisdiction may attend this public meeting. This meeting is for oral presentations only. Meeting minutes are not taken and there is no Question and Answer component to the meeting. In order for comments to be considered, they must be presented in writing through the formal comment process.

Advance registration is required. Registration is online at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/DMEMAC/webinars/formDMEOM.asp and must be completed no later than COB Wednesday, January 8, 2014. Registrants must include their name, contact information, organization, whether attending in person or via teleconference and the policy(s) upon which oral presentations will be made in their registration information. Oral comments will be limited to ten (10) minutes per presenter. Multiple speakers from the same organization, company or sponsor will not receive separate speaking time allotments in order to allow for as much diversity of comment as possible. The DME MAC medical directors request that presenters provide four (4) copies of the presentation materials at the meeting (electronic media preferred).

To access the meeting via teleconference, please use the following information:

Conference Title: Draft Medical Policy Open Meeting

Host Name: Eileen Moynihan, MD

Company Name: Noridian Healthcare Solutions

Conference dial-in numbers:
- US Toll free: 1-877-336-1828
- International Toll: 1-404-443-6396

Confirmation Number: 7017183

Participant information:
- Please dial in 3-5 minutes prior to conference start time.
- Your line will be placed on hold with music until conference starts.

Lines will remain muted throughout the conference except for the commenter. Registered commenters should follow the operator instructions to be placed in the queue to present. Only pre-registered commenters will be allowed to present.

When all comments have been received, they will be reviewed and revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on the individual DME MAC web sites, allowing for adequate notice before the policies' effective date.

Thank you for your participation in our policy revision process.

Sincerely,
Robert D. Hoover, Jr., MD, MPH, FACP

On behalf of:

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

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

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

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

Clarification of Face-to-Face Encounter Requirements for Certain Durable Medical Equipment (DME) (GEN)

On December 3, 2013, the Centers for Medicare & Medicaid Services (CMS) published an announcement (**http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/FacetoFaceEncounterRequirementforCertainDurableMedicalEquipment.html**) regarding the delay in enforcement of the face-to-face requirements established by Section 6407 of the *Affordable Care Act*. This announcement clarified that the enforcement delay only applies to the new DME face-to-face requirements. While active enforcement of the face-to-face requirements has been postponed until a future date to be announced in Calendar Year 2014, the delay does not impact provisions related to written orders prior to delivery. NHIC will begin enforcement of the written order prior to delivery requirement for dates of service (DOS) on or after January 1, 2014.

Accordingly, as of July 1, 2013, the DME items on the Specified Covered Items list require that the supplier obtain a detailed written order prior to delivery. All written orders shall follow the guidance in the CMS *Program Integrity Manual* (Internet-only manual, Publication. 100-08), Chapter 5, Section 5.2.3,
(**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c05.pdf**)
and shall include, at a minimum, the following elements listed in the regulation:

1. The beneficiary's name;
2. The DME item ordered;
3. The prescribing practitioner's National Provider Identification (NPI);

4. The signature of the prescribing practitioner; and,
5. The date of the order.

The requirements listed in the regulation do not supersede other CMS requirements for detailed written orders. Per the standard documentation guidelines, detailed written orders must also include the following:

1. Physician's Name;
2. Start date of the order (if different from the date of the order);
3. Signature date personally entered by the ordering practitioner;
4. Dosage or concentration, if applicable;
5. Route of administration, if applicable;
6. Frequency of use;
7. Duration of infusion, if applicable;
8. Quantity to be dispensed; and
9. Number of refills, if applicable.

Failure to obtain a valid detailed written order prior to delivery will result in the item being denied as excluded by statute.

For additional information concerning the face-to-face encounter requirements and a list of DME items on the Specified Covered List, please refer to the CMS Medicare Learning Network article, "*Detailed Written Orders and Face-to-Face Encounters*" (MM8304) (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8304.pdf**).

Face-to-Face and Written Order Requirements for High Cost DME (GEN)

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 and delivery of 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 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 before the date of delivery (DOS).
- 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.

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,

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

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

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

Eileen Moynihan, MD
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions

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

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 and delivery of 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 just like 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 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 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 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
- Power Mobility Devices
- Pressure Reducing Support Surfaces - Group 1
- Pressure Reducing Support Surfaces - Group 3
- Respiratory Assist Devices
- Seat Lift Mechanisms
- Speech Generating Devices
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Wheelchair Options and Accessories
- Wheelchair Seating

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.

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

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.

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, 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

HCPCS Code	Description
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
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive

HCPCS Code	Description
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

HCPCS Code	Description
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

Documentation Reminder - Therapeutic Shoes (SPE)

The Centers for Medicare & Medicaid Services (CMS) Supplier Standards (42 CFR 424.57) require that suppliers of therapeutic shoes for persons with diabetes are required to perform an in-person visit with the beneficiary for the purpose of determining fit. Recently questions have arisen about the documentation of this in-person visit.

Claim denials by NHIC Medical Review staff have resulted from failure of the supplier to document the fitting of the shoes. In many cases, these claims have an attestation from the beneficiary about the quality of the shoe and/or insert fit; however, there is no objective assessment from the supplier of the shoes regarding fit. This objective assessment by the supplier is a critical component of the delivery process.

Medicare and the DME MACs view the supplier of the shoe as a skilled professional with training in the proper assessment of fit and the relationship of the shoe and/or insert to correction of the underlying foot condition. Reliance solely on a beneficiary's statement about fit and comfort as documentation that the supplier performed an in-person fitting and assessment is inappropriate and will result in claim denials. Subjective statements from the beneficiary are only one component of fit assessment; the supplier must make an independent, objective assessment of the fit as well. Both components must be documented to meet the Medicare policy requirements.

Payment Rules Reminder - Home Oxygen Initial Qualification Testing - Joint DME MAC Publication (OXY)

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when the 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.

Qualifying Test Results

The results of a blood gas 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 of 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.
Pulse oximetry 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.

Qualified Testing Providers

Oxygen qualification testing may only be performed by providers designated as qualified to perform such testing. Testing done by non-qualified entities is not valid for purposes of qualification for Medicare reimbursement for home oxygen. The LCD states:

> All oxygen qualification testing must be performed in-person by a physician or other medical professional qualified to conduct oximetry testing. With the exception of overnight oximetry (see below), unsupervised or remotely supervised home testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment.
>
> The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test - i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. These prohibitions do not extend to blood gas studies performed by a hospital certified to do such tests.

For purposes of meeting the "qualified provider" criterion, this policy uses a determination based upon two criteria:

1. whether the test performed meets the applicable requirements for Medicare billing of the specific test, and
2. the entity that performed the test meets the applicable requirements for Medicare billing of the specific test.

Note that this does not require that the specific test be actually billed and/or paid, only that the testing entity meet the requirements necessary to perform and bill Medicare for the actual test. The following describes payment scenarios:

- Under Medicare Part A
  - During a Part A covered stay payment is bundled such that services rendered are covered under a lump sum payment by Medicare. In this case, oxygen qualification testing performed in a hospital, nursing facility, Home Health or Hospice or other covered Part A episode meets the "qualified provider" standard.
  - Outside of a covered Part A stay, testing done by a Part A provider does not meet the requirement and is not valid for qualification of home oxygen reimbursement unless the entity is also a qualified provider of diagnostic testing or laboratory services for individual testing performed outside of a covered Part A stay.

- Under Medicare Part B
  - Testing performed and covered as "incident to" physician services meets the "qualified provider" standard.
  - Laboratory testing is also reimbursed "a la carte" or on a per test basis. The entity performing the specific test must meet the requirements to perform the specific test. Testing done by an entity that meets the requirements to bill for the individual test meets may be used for oxygen qualification.

Timing of Testing

For initial qualification testing scenarios, the qualification testing must be performed within the 30 days before the initial date of certification (prescription date).

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.

Refer to the Local Coverage Determination, related Policy Article and the *DME MAC Supplier Manual* for additional information concerning the payment rules for reimbursement of oxygen and oxygen equipment.

Medicare Provider Enrollment, Chain and Ownership System (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 6, 2014, implementation of specific edits will occur that will restrict 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). Help your DMEPOS supplier to continue providing quality services to your Medicare patients 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 doing so, if you have a PECOS record, ensure that your NPI is in it. If it is not, update your enrollment record.

For additional information consult with your Local A/B Medicare Administrative Contractor.

Sincerely,

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

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

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

Eileen Moynihan, MD
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions

Supplier "Abandonment" of Beneficiaries and Oxygen Equipment (OXY)

Recently the Centers for Medicare & Medicaid Services (CMS) issued instructions to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to process claims for replacement oxygen and oxygen equipment in the event that a supplier voluntarily exits the Medicare oxygen business (for example, goes out of business) and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and non-competitive bid areas.

In these situations, CMS considers the equipment "lost" under the Medicare regulations at 42 CFR §414.210(f), which provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen or irreparably damaged. When considering "lost" equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier furnishing replacement oxygen and oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

Obligations of Exiting Supplier

Suppliers voluntarily exiting the Medicare program are reminded that they are in violation of their regulatory and statutory obligations. Section 1834(a)(5)(F)(ii)(I) requires that the supplier that received the 36th month rental payment continue furnishing the oxygen equipment during any period of medical need for the reminder of the equipment's reasonable useful lifetime. Further, 42 CFR 414.226(g)(1) requires, barring a few exceptions, that the supplier that furnishes oxygen equipment in the first month during which payment is made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends. As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier standards set forth at 42 CFR 424.535(c). Violations of the supplier standards are reported to the National Supplier Clearinghouse.

Suppliers voluntarily exiting the program must provide a ninety (90) day notice to the beneficiary of their intention to no longer provide oxygen therapy services. This must be provided in writing and must take one of two forms:

1. A letter to the beneficiary notifying them of the supplier's intention to discontinue oxygen therapy services. The letter must specify a date upon which this will occur; or,
2. Working with the beneficiary, a letter to a new supplier selected by the beneficiary, transferring provision of oxygen therapy services to the new supplier as of a specific date.

Obligations of New Supplier

For suppliers who receive beneficiaries from providers who have elected to voluntarily exit the Medicare oxygen business, claims for replacement equipment must:

1. Include the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,
2. Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.

In addition to providing the above information on the replacement equipment claim, in the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement are either:

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier's services were being terminated; or,
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program.

If the new supplier is unable to obtain the documentation required above, the supplier may not append the RA modifier to the claim and may not initiate a new 36-month capped rental period.

Suppliers accepting transfer of beneficiaries are reminded that all Medicare rules apply. This includes obtaining:

1. New order;
2. New initial Certificate of Medical Necessity (CMN)
    a. Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
    b. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.
3. Medical necessity documentation as outlined in the Oxygen LCD.

Suppliers should review the entire Oxygen LCD and Policy Article for additional information on coding, coverage and documentation requirements.

Breathe NIOV™ - Coding Reminder - Revised January 2014 - Joint DME MAC Publication (OXY)

This article updates and replaces the previous version published in December 2012.

The Non-invasive OPEN Ventilation System (NIOV™) by Breathe Technologies, Inc. provides positive pressure inspiratory support for patients using oxygen. This product consists of multiple components - control unit, flow regulator, connecting hose and nasal interface (pillows). E1352 is an all-inclusive code for this product that includes all components. For the BREATHE NON INVASIVE OPEN VENTILATION (NIOV) SYSTEM, the HCPCS code listed below should be used when billing the DME MACs:

E1352 OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE.

If pillows and hoses are billed separately for replacement purposes use:

A9900 (MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE)

Based on clinical data provided by the manufacturer, this item is effective only when used in conjunction with oxygen; therefore, it is classified as an accessory to oxygen equipment. E1352 is not eligible for separate billing as stand-alone DME under this classification.

Oxygen reimbursement is a bundled payment. All options, supplies and accessories are considered included in the monthly rental payment for oxygen equipment. Oxygen rental is billed using the appropriate code for the provided oxygen equipment. Separately billed options, accessories or supply items will be denied as unbundling.

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

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

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/**

Coding Guideline - K0900 (CUSTOM DURABLE MEDICAL EQUIPMENT, OTHER THAN WHEELCHAIRS) - Joint DME MAC Publication (GEN)

A new HCPCS code, K0900, has been created for use with custom fabricated durable medical equipment other than wheelchairs. 42 CFR §414.224(a) describes the requirements for custom fabricated, stating in order to be considered a customized DME item, a covered item (including a wheelchair) must be:

1. Uniquely constructed or substantially modified for a specific beneficiary according to a physician's description and orders; and,
2. So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

Supplier and manufacturers must remember that the definition of custom fabricated does not include:

1. Items that are measured, assembled, fitted, or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items); or,
2. Items that have been assembled by a supplier, or ordered from a manufacturer, who makes available customized features, modification or components intended for an individual patient's use in accordance with instructions from the patient's physician.

These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in equipment being considered as customized.

§414.224(b) further provides that the lump-sum payment made for purchase of the customized item is based on the Medicare contractor's individual consideration and judgment of a reasonable payment amount for each item. The contractor's individual consideration takes into account:

1. Written documentation on the item's costs (including design, fabrication, and assembly costs), including at least the costs of labor (to the extent that they are reasonable) of those actually performing the customization; and
2. The types of materials (to the extent that they are reasonable) used in custom fabricating or substantially modifying an item.

In order to determine a reimbursement amount, the supplier must provide a detailed description of each phase of the construction process, materials used, the labor skills needed to fabricate or modify the item, etc. (not all-inclusive). When submitting claims for items using K0900 supplier must have in their files:

1. A detailed written order for the item
2. Information from the medical record justifying that the applicable medical necessity requirements from the relevant policy are met
3. Information from the medical record showing the ordering physician's description of the item to be provided
4. Information from the supplier providing a detailed description of the item provided including a cost breakdown (for time and each material used in fabrication of the item); construction and/or assembly description; and an explanation about why the item should be considered as custom fabricated.

This information must be available upon request.

Pricing differentials between the fee for an established HCPCS code and the suppliers cost or desired charge for any item are not a justification for the use of K0900 or any other NOC (not-otherwise-classified) code such as E1399 [DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS]. Correct coding rules require the use of the most specific HCPCS for any item.

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

Coverage Reminder - Speech Generating Devices - Joint DME MAC Publication (SPE)

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination for Speech Generating Devices (IOM 100-2 §50.1), specifies that in order for a speech generating device (SGD) to be considered for reimbursement under the Durable Medical Equipment (DME) benefit, it must be a "dedicated" device. Dedicated device means that the SGD must be a device limited solely to the generation of speech, for use only by the individual who has a severe speech impairment. The NCD states:

> *Devices that would not meet the definition of speech generating devices and therefore, do not fall within the scope of §1861(n) of the Act are characterized by:*

- *Devices that are not dedicated speech devices, but are devices that are capable of running software for purposes other than for speech generation, e.g., devices that can also run a word processing package, an accounting program, or perform other than non-medical function.*

- *Laptop computers, desktop computers, or PDA's which may be programmed to perform the same function as a speech-generating device, are noncovered since they are not primarily medical in nature and do not meet the definition of DME. For this reason, they cannot be considered speech-generating devices for Medicare coverage purposes.*

- *A device that is useful to someone without severe speech impairment is not considered a speech-generating device for Medicare coverage purposes.*

This benefit does not extend coverage to the broader range of augmentative and alternative communications devices (AAC) that have capabilities exceeding the sole function(s) of speech generation such as (not all-inclusive): wireless and cellular communication capabilities, environmental control capability, non-speech generating software (e.g., games, word processing, email).

Products provided as a dedicated device that have the capability to be expanded with additional hardware and/or software or where additional functionality may be made available by "unlocking" hardware or software limitations do not meet the NCD requirement for classification as a dedicated device. Such non-dedicated devices are not eligible for coverage and should be coded A9270 (Noncovered item or service).

SGD Software

For the purposes of Medicare reimbursement, the term SGD also describes Speech Generating Device software/programs installed for use on a personal computer or other device. While the software/program is a covered benefit when all other coverage criteria in the SGD Local Coverage Determination (LCD) and related Policy Article (PA) are met, the device that runs the SGD software (e.g. laptop computer, tablet, smartphone) is not a covered item as it is not primarily medical in nature and does not meet the definition of DME. The installation and technical support of the program on a non-dedicated device is not separately reimbursable. Finally, technical support or repair (if necessary) is non-covered for the non-dedicated device hosting the SGD software.

Suppliers are reminded that accessories/peripherals (e.g. (not all-inclusive)- keyboards, mice, pointing devices, ocular tracking systems) for use with an SGD are eligible for reimbursement only after a determination has been made that the accessory/peripheral is essential for the effective use of a dedicated SGD as described above and all other coverage criteria in the SGD Local Coverage Determination (LCD) and related Policy Article (PA) are met. In addition, accessories/peripherals for use on a non-dedicated device running SGD software are non-covered.

Suppliers should read the entire LCD and related Policy Article for additional coverage, coding and documentation requirements.

Effective for claims with dates of service on or after **September 1, 2014**, the only products which may be billed to Medicare for Speech Generating Devices are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification List in DMECS maintained on the PDAC website, **https://www.dmepdac.com/dmecsapp/do/search**. Products which have not received coding verification review from the PDAC must be billed with code A9270. Products previously listed on DMECS will be end dated on **August 31, 2014**.

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

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

Payment Rules - Continuous Passive Motion Machines - DME MAC Joint Publication (SPE)

Medicare covers continuous passive motion devices (CPM) under the Durable Medical Equipment Benefit. Reasonable and Necessary (R&N) requirements are set out in CMS National Coverage Determination 280.1. The NCD states:

> *Continuous passive motion devices are devices Covered (sic) for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient's home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.*

Note that CMS has clarified to the DME MACs that in addition to a total knee replacement, a CPM device is also covered following the revision of a major component of a previous total knee replacement (i.e., tibial components or femoral component).

Additional billing instructions are provided in CMS *Claim Processing Manual* (Internet-only Publication 100-04) Chapter 20 Section 30.2.1 which states:

> *Contractors make payment for each day that the device is used in the patient's home. No payment can be made for the device when the device is not used in the patient's home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period.*

Coding Guidelines

Continuous Passive Motion devices are classified under two HCPCS codes:

- E0935 - CONTINUOUS PASSIVE MOTION EXERCISE DEVICE FOR USE ON KNEE ONLY
- E0936 - CONTINOUS PASSIVE MOTION EXERCISE DEVICE FOR USE OTHER THAN KNEE

Recent questions regarding the exact nature of these devices reveal confusion regarding the nature and functionality of these devices. These coding guidelines clarify the types of products described by the CPM codes.

The first test of any durable medical equipment is that it be durable and capable of repeated use over the expected five-year useful life expectancy. Elastic, fabric, single use, or light plastic devices are not durable and do not meet the test for DME.

Secondly, the equipment must be capable of continuous passive motion of the affected limb. These characteristics mean that the device must have inherent within itself the ability to move the affected limb:

- in an appropriate plane of motion
- in a continuous fashion
- at the same rate of speed
- for a prescribed length of time
- with adjustable limits of range of motion
- with an identical range of motion in each cycle
- without any input from the patient by the contralateral or other limbs
- with easily accessible safety or cutoff switches

These characteristics require that the device be electrically powered, either by AC current or battery. Battery powered models must have an AC adapter for long term use. CPM machines must meet all these characteristics in order to be coded as E0935 or E0936.

Patient-controlled stretch devices are not considered CPM devices and must not be billed using codes E0935 or E0936. These devices are considered exercise equipment and are coded A9300.

Coverage and Documentation

Based upon the NCD, Continuous passive range of motion devices (CPM) are covered by Medicare only if all of the following are met:

- CPM treatment is started after a total knee replacement or a revision of a major component of a previously performed total knee replacement. CPMs are not covered after any other type of knee or joint surgery.

- CPM treatment must be applied within 48 hours of surgery to be eligible for Medicare coverage

Claims for items that do not meet these criteria will be denied as not reasonable and necessary.

Coverage is limited to 21 days from the date of surgery. The DME MAC should be billed only for those days of CPM treatment after discharge from the hospital.

The supplier must have a detailed written order signed and dated by the ordering physician in their file prior to submitting a claim for a CPM.

In the event of an audit there must be information in the medical record showing that the coverage criteria are met.

When billing for a CPM (HCPCS code E0935), all of the following documentation must be included with the claim:
- Type of knee surgery performed; and,
- Date of surgery; and,
- Date of application of CPM; and,
- Date of discharge from the hospital

Claims submitted without this required information will be denied as not reasonable and necessary.

Refer to the *Supplier manual* for additional information about 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/**

Correct Coding - ApniCure Winx® Sleep Therapy System - Joint DME MAC Publication (SPE)

The ApniCure, Inc. Winx® Sleep Therapy System uses continuous low suction delivered to the oral cavity via a fitted mouthpiece to move the soft tissue and increase the size of the airway in the retropharynx and oral cavity. ApniCure claims that this increased airway size is an effective treatment for Obstructive Sleep Apnea (OSA) (ICD-9 327.23).

The product consists of a system console, connecting tubing and an oral interface (mouthpiece). Product coding was assigned in the January 2014 HCPCS code update.
- Console - E0600 (RESPIRATORY SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC)
- Tubing - A7002 (TUBING, USED WITH SUCTION PUMP, EACH)
- Oral interface - A7047 (ORAL INTERFACE USED WITH RESPIRATORY SUCTION PUMP, EACH)

Payment rules for E0600 and A7002 are addressed in the Local Coverage Determination (LCD) for Suction Pumps. HCPCS code A7047 will be added to that LCD. The current LCD does not provide reimbursement for E0600 when used to treat OSA.

A7047 was created to describe the oral interface used as part of the Winx or similar systems. This code is not to be used for oral appliances used to treat OSA or for any other type of oral suction appliances. Do not use the oral appliance HCPCS codes E0485 or E0486 for this interface.

Refer to the Suction Pumps LCD and related Policy Article for additional information about E0600, A7002 and A7047.

Refer to the Oral Appliances Used for the Treatment of Obstructive Sleep Apnea LCD and related Policy Article for additional information about E0485 and E0486.

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/**

Correct Coding - Liners Used With Positive Airway Pressure (PAP) Mask (PDAC Article) (SPE)

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

A liner is a device which is placed between the patient's skin and the PAP mask interface. Liners used with a PAP mask are made of cloth, silicone or other materials. A liner used in conjunction with a PAP mask is considered comfort/convenience item.

There is no additional payment for liners used with a PAP mask. These products should be coded A9270 (Noncovered item or service) in accordance with the *Medicare Benefit Policy Manual* 100-2 Chapter 15 Section 110.1.

Liners are not interfaces for use with a PAP mask. Consequently, liners should not be billed as replacement features of a PAP mask such as A7031 (Face mask interface, replacement for full face mask, each) or A7032 (Cushion for use on nasal mask interface, replacement only, each).

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/**

Manual Wheelchair Bases (PDAC Article) (MOB)

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

Recently it has been brought to the attention of the Pricing, Data Analysis and Coding Contractor (PDAC) that manufacturers are submitting incomplete wheelchair bases on Coding Verification Review Applications. For Medicare payment purposes a manual wheelchair HCPCS codes describes a complete product as described in the bundling table contained in the Wheelchair Options and Accessories LCD. Column I codes contains all of the items listed in Column II.

Column I	Column II
Power Operated Vehicle (K0800-K0812)	All options and accessories
Rollabout Chair (E1031)	All options and accessories
Transport Chair (E1037, E1038, E1039)	All options and accessories except E0990, K0195
Manual Wheelchair Base (E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009)	E0967, E0981, E0982, E0995, E2205, E2206, E2210, E2220, E2221, E2222, E2224, E2225, E2226, K0015, K0017, K0018, K0019, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0052, K0069, K0070, K0071, K0072

Column I	Column II
Power Wheelchair Base Groups 1 and 2 (K0813-K0843)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0098
Power Wheelchair Base Groups 3, 4, and 5 (K0848-K0891)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0098
E0973	K0017, K0018, K0019
E0950	E1028
E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems (E1002, E1003, E1004, E1005, E1006, E1007, E1008)	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1009, E1010	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E2325	E1028
E1020	E1028
K0039	K0038
K0045	K0043, K0044
K0046	K0043
K0047	K0044
K0053	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047
K0069	E2220, E2224
K0070	E2211, E2212, E2224
K0071	E2214, E2215, E2225, E2226
K0072	E2219, E2225, E2226
K0077	E2221, E2222, E2225, E2226
K0195	E0995, K0042, K0043, K0044, K0045, K0046, K0047

A manual wheelchair base includes but is not limited to:

- a complete frame
- propulsion wheels and brakes
- casters
- a seat or seat pan (which can accommodate a wheelchair seat cushion or other seating system)
- a back frame
- standard leg and footrests
- armrests
- safety accessories (other than those separately billable in the Wheelchair Accessories Local Coverage Determination).

As described above, the following HCPCS codes are included in the allowance for the base wheelchair on initial issue:

E0967 MANUAL WHEELCHAIR ACCESSORY HAND RIM WITH PROJECTIONS ANY TYPE EACH

E0981 WHEELCHAIR ACCESSORY SEAT UPHOLSTERY REPLACEMENT ONLY EACH

E0982 WHEELCHAIR ACCESSORY BACK UPHOLSTERY REPLACEMENT ONLY EACH

E0995 WHEELCHAIR ACCESSORY CALF REST/PAD EACH

E2205 MANUAL WHEELCHAIR ACCESSORY HANDRIM WITHOUT PROJECTIONS (INCLUDES ERGONOMIC OR CONTOURED) ANY TYPE REPLACEMENT ONLY EACH

E2206 MANUAL WHEELCHAIR ACCESSORY WHEEL LOCK ASSEMBLY COMPLETE EACH

E2210 WHEELCHAIR ACCESSORY BEARINGS ANY TYPE REPLACEMENT ONLY EACH

E2220	MANUAL WHEELCHAIR ACCESSORY SOLID (RUBBER/PLASTIC) PROPULSION TIRE ANY SIZE EACH
E2221	MANUAL WHEELCHAIR ACCESSORY SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE) ANY SIZE EACH
E2222	MANUAL WHEELCHAIR ACCESSORY SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL
E2224	MANUAL WHEELCHAIR ACCESSORY PROPULSION WHEEL EXCLUDES TIRE ANY SIZE EACH
E2225	MANUAL WHEELCHAIR ACCESSORY CASTER WHEEL EXCLUDES TIRE ANY SIZE REPLACEMENT ONLY
E2226	MANUAL WHEELCHAIR ACCESSORY CASTER FORK ANY SIZE REPLACEMENT ONLY EACH
K0015	DETACHABLE NON-ADJUSTABLE HEIGHT ARMREST EACH
K0017	DETACHABLE ADJUSTABLE HEIGHT ARMREST BASE EACH
K0018	DETACHABLE ADJUSTABLE HEIGHT ARMREST UPPER PORTION EACH
K0019	ARM PAD EACH
K0042	STANDARD SIZE FOOTPLATE EACH
K0043	FOOTREST LOWER EXTENSION TUBE EACH
K0044	FOOTREST UPPER HANGER BRACKET EACH
K0045	FOOTREST COMPLETE ASSEMBLY
K0046	ELEVATING LEGREST LOWER EXTENSION TUBE EACH
K0047	ELEVATING LEGREST UPPER HANGER BRACKET EACH
K0050	RATCHET ASSEMBLY
K0052	SWINGAWAY DETACHABLE FOOTRESTS EACH
K0069	REAR WHEEL ASSEMBLY COMPLETE WITH SOLID TIRE SPOKES OR MOLDED EACH
K0070	REAR WHEEL ASSEMBLY COMPLETE WITH PNEUMATIC TIRE SPOKES OR MOLDED EACH
K0071	FRONT CASTER ASSEMBLY COMPLETE WITH PNEUMATIC TIRE EACH
K0072	FRONT CASTER ASSEMBLY COMPLETE WITH SEMI-PNEUMATIC TIRE EACH

Manual wheelchairs submitted to the PDAC that are incomplete will receive a "No HCPCS Code Assigned" designation. If the manual wheelchair base is incomplete, any accessories associated with the application will not be processed.

HCPCS Code Update - 2014 (PDAC Article) (GEN)

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

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2014.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2014.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2013, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2014.

There is no grace period that would allow submission of the discontinued code for dates of service in 2014.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2014.

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

Ankle-Foot/Knee-Ankle-Foot Orthosis

	Added Code	
Code	**Narrative**	
L4361	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	
L4387	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	
L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, OFF-THE-SHELF	
	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L1902	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, OFF-THE-SHELF
L1904	ANKLE FOOT ORTHOSIS, MOLDED ANKLE GAUNTLET, CUSTOM-FABRICATED	ANKLE ORTHOSIS, ANKLE GAUNTLET, CUSTOM-FABRICATED
L1906	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, OFF-THE-SHELF
L1907	AFO, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS, CUSTOM FABRICATED	ANKLE ORTHOSIS, SUPRAMALLEOLAR WITH STRAPS, WITH OR WITHOUT INTERFACE/PADS, CUSTOM FABRICATED
L4350	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID, INCLUDES ANY TYPE INTERFACE (E.G. , PNEUMATIC, GEL), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ANKLE CONTROL ORTHOSIS, STIRRUP STYLE, RIGID, INCLUDES ANY TYPE INTERFACE (E.G., PNEUMATIC, GEL), PREFABRICATED, OFF-THE-SHELF
L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4370	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	PNEUMATIC FULL LEG SPLINT, PREFABRICATED, OFF-THE-SHELF
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L4398	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	FOOT DROP SPLINT, RECUMBENT POSITIONING DEVICE, PREFABRICATED, OFF-THE-SHELF

Immunosuppressive Drugs

	Added Code	
Code	**Narrative**	
J7508	TACROLIMUS, EXTENDED RELEASE, ORAL, 0.1 MG	
	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
J7507	TACROLIMUS, ORAL, PER 1 MG	TACROLIMUS, IMMEDIATE RELEASE, ORAL, 1 MG

Intravenous Immune globulin

	Added Code
Code	**Narrative**
J1556	INJECTION, IMMUNE GLOBULIN (BIVIGAM), 500 MG
Q2052	SERVICES, SUPPLIES AND ACCESSORIES USED IN THE HOME UNDER THE MEDICARE INTRAVENOUS IMMUNE GLOBULIN (IVIG) DEMONSTRATION

Knee Orthoses

	Added Code	
Code	**Narrative**	
L1812	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, OFF-THE-SHELF	
L1833	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, OFF-THE SHELF	
L1848	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, OFF-THE-SHELF	
	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1830	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, IMMOBILIZER, CANVAS LONGITUDINAL, PREFABRICATED, OFF-THE-SHELF
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1836	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S), INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, RIGID, WITHOUT JOINT(S), INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1850	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	KNEE ORTHOSIS, SWEDISH TYPE, PREFABRICATED, OFF-THE-SHELF

Lower Limb Orthotics

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INIDIVIDUAL WITH EXPERTISE
L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Lower Limb Prostheses

	Added Code
Code	**Narrative**
L5969	ADDITION, ENDOSKELETAL ANKLE-FOOT OR ANKLE SYSTEM, POWER ASSIST, INCLUDES ANY TYPE MOTOR(S)

Manual Wheelchair Bases

	Added Code
Code	**Narrative**
K0008	CUSTOM MANUAL WHEELCHAIR/BASE (effective 7/1/2013)

Miscellaneous

	Added Code
Code	**Narrative**
A4555	ELECTRODE/TRANSDUCER FOR USE WITH ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, REPLACEMENT ONLY
E0766	ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES, ANY TYPE
K0900	CUSTOMIZED DURABLE MEDICAL EQUIPMENT, OTHER THAN WHEELCHAIR (effective 7/1/2013)

Oral Antiemetic Drugs

	Added Code	
Code	**Narrative**	
Q0161	CHLORPROMAZINE HYDROCHLORIDE, 5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	
	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
Q0165	PROCHLORPERAZINE MALEATE, 10 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0164
Q0168	DRONABINOL, 5 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0167
Q0170	PROMETHAZINE HYDROCHLORIDE, 25 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0169
Q0171	CHLORPROMAZINE HYDROCHLORIDE, 10 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0161
Q0172	CHLORPROMAZINE HYDROCHLORIDE, 25 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0161
Q0176	PERPHENAZINE, 8MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	Q0175
Q0178	HYDROXYZINE PAMOATE, 50 MG, ORAL, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR AN	Q0177

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
	IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN	

Orthopedic Footwear

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L3100	HALLUS-VALGUS NIGHT DYNAMIC SPLINT	HALLUS-VALGUS NIGHT DYNAMIC SPLINT, PREFABRICATED, OFF-THE-SHELF
L3170	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, EACH	FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, PRAFABRICATED, OFF-THE-SHELF, EACH

Ostomy Supplies

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A5081	CONTINENT DEVICE; PLUG FOR CONTINENT STOMA	STOMA PLUG OR SEAL, ANY TYPE

Oxygen and Oxygen Equipment

	Added Code
Code	**Narrative**
E1352	OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE	CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE

Power Mobility Devices

	Added Code
Code	**Narrative**
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR BASE (effective 7/1/2013)

Spinal Orthoses: Cervical, TLSO and LSO

	Added Code
Code	**Narrative**
L0455	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0457	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0467	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF

	Added Code	
Code	**Narrative**	
L0469	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF	
L0641	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
L0642	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
L0643	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
L0648	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
L0649	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
L0650	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
L0651	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF	
	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L0120	CERVICAL, FLEXIBLE, NON-ADJUSTABLE (FOAM COLLAR)	CERVICAL, FLEXIBLE, NON-ADJUSTABLE, PREFABRICATED, OFF-THE-SHELF (FOAM COLLAR)
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT, PREFABRICATED, OFF-THE-SHELF
L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO PIECE	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO-PIECE, PREFABRICATED, OFF-THE-SHELF

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION, PREFABRICATED, OFF-THE-SHELF
L0450	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, INCLUDES FITTING AND SHAPING THE FRAME, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0625	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, OFF-THE-SHELF

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0628	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L0980	PERONEAL STRAPS, PAIR	PERONEAL STRAPS, PREFABRICATED, OFF-THE-SHELF, PAIR
L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4)	STOCKING SUPPORTER GRIPS, PREFABRICATED, OFF-THE-SHELF, SET OF FOUR (4)
L0984	PROTECTIVE BODY SOCK, EACH	PROTECTIVE BODY SOCK, PREFABRICATED, OFF-THE-SHELF, EACH

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
L0430	SPINAL ORTHOSIS, ANTERIOR-POSTERIOR-LATERAL CONTROL, WITH INTERFACE MATERIAL, CUSTOM FITTED (DEWALL POSTURE PROTECTOR ONLY)	NONE

Suction Pumps

	Added Code
Code	**Narrative**
A7047	ORAL INTERFACE USED WITH RESPIRATORY SUCTION PUMP, EACH

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A9272	MECHANICAL WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, EACH	WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, ANY TYPE, EACH

Upper Limb Orthotics

	Added Code
Code	**Narrative**
L3678	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, OFF-THE-SHELF, ANY TYPE
L3916	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3918	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED, OFF-THE-SHELF
L3924	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3930	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, OFF-THE-SHELF

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L3650	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, PREFABRICATED, OFF-THE-SHELF
L3660	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, OFF-THE-SHELF
L3670	SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, OFF-THE-SHELF
L3675	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, OFF-THE-SHELF
L3677	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3710	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINTS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ELBOW ORTHOSIS, ELASTIC WITH METAL JOINTS, PREFABRICATED, OFF-THE-SHELF
L3762	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	ELBOW ORTHOSIS, RIGID, WITHOUT JOINTS, INCLUDES SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENTS, ANY TYPE	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3908	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WRIST HAND ORTHOSIS, WRIST EXTENSION CONTROL COCK-UP, NON MOLDED, PREFABRICATED, OFF-THE-SHELF
L3912	HAND FINGER ORTHOSIS, FLEXION GLOVE WITH ELASTIC FINGER CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND FINGER ORTHOSIS (HFO), FLEXION GLOVE WITH ELASTIC FINGER CONTROL, PREFABRICATED, OFF-THE-SHELF
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
L3925	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), NON TORSION JOINT/SPRING, EXTENSION/FLEXION, MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L3927	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G. STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	FINGER ORTHOSIS, PROXIMAL INTERPHALANGEAL (PIP)/DISTAL INTERPHALANGEAL (DIP), WITHOUT JOINT/SPRING, EXTENSION/FLEXION (E.G. STATIC OR RING TYPE), MAY INCLUDE SOFT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE

Wheelchair Options/Accessories

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E2300	POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM	WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE
E2301	POWER WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM	WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM, ANY TYPE

Completion of Certificates of Medical Necessity (GEN)

Dear Physician:

Certificates of medical necessity, commonly known as CMNs, are documents used by the DME MACs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both, the medical need for, and the utilization of all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are your partners in caring for your patient. They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the *Social Security Act*, the law governing Medicare. Section 1842(p) (4) of the Act provides that:

[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Additionally, please remember that the information in the beneficiary's medical records must corroborate all information on the CMN. Help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Items Provided on a Recurring Basis and Request for Refill Requirements - Reminder (GEN)

Requirements

For all DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one- or three-month quantity at a time. See below for billing frequencies.

Documentation Requirements

A routine refill prescription is not needed. A new prescription is needed when:

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

For items that the patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary's name or authorized representative if different from the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) - The Supplier should assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., Positive Airway Pressure and Respiratory Assist Device supplies) - The supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

This information must be kept on file and be available upon request.

Billing Frequencies

For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

For additional information, refer to CMS' *Program Integrity Manual*, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, and the applicable Local Coverage Determinations and the *Supplier Manual*.

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 October 01, 2013 through December 31, 2013:

- The review involved DCRs of 6,088 claims (including reopenings)
- Of the 6,088 claims reviewed, 3,152 claims were denied resulting in a claim denial rate of 52%.
- An additional 2,923 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

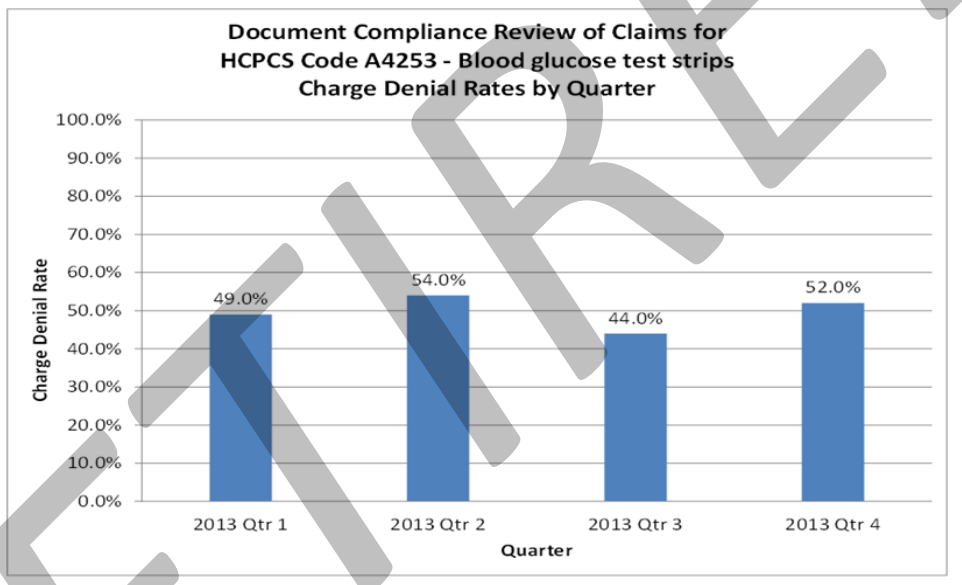
Primary Reasons for Denial

Based on review of the documentation received, following are common reasons for denial (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/dme/mrbulletinpca.aspx
- 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 Prepay Probe for Lumbar-Sacral Orthoses (O&P)

Current Review Results

The DME MAC Jurisdiction A has completed the prepayment probe review of claims for Lumbar-Sacral Orthoses (LSO):

- HCPCS code L0631 is a Lumbar-Sacral Orthoses, sagittal control with rigid anterior and posterior panels, posterior extends from sacroccoccygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment.

- HCPCS code L0637 is a Lumbar-Sacral Orthoses, sagittal-cornal control with rigid anterior and posterior frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment.

This probe was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 107 claims submitted by 46 suppliers. These claims were reviewed from **July 16, 2013 - September 27, 2013**. Responses to the Additional Documentation Request (ADR) were not received for 34 (31%) of the claims. For the remaining 73 claims, 8 claims were allowed and 65 were denied resulting in a claim denial rate of 89%. 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 76.8%.

Primary Reasons for Denial

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

Detailed Written Orders

- 33% of denied claims were missing a Detailed Written Order for supplies being billed.
- 6% of denied claims were incomplete
  - 2% of Detailed Written Orders submitted were not legible.
  - 3% of Detailed Written Orders were not dated.
  - 1% of Detailed Written Orders did not list a beneficiary name.

Medical Record Documentation issues

- 18% of the denied claims were missing the clinical documentation to support medical necessity.
- 5% of denied claims pertain to clinical documentation

- 2% of Clinician Notes submitted show different beneficiary than stated within the claim submitted.
- 1% of Clinician Notes submitted did not satisfy medical necessity. The documentation submitted did not demonstrate the treatment of an illness or injury to improve functioning of the spine or trunk on the body.
- 2% Medical documentation was not authenticated by the clinician conducting the exam.

Proof of delivery

- 66% of the denied claims were missing the proof of delivery.
- 7% Proof of Delivery included delivery tickets not having required documentation
  - 5% Delivery ticket did not include signature of beneficiary or beneficiary representative; unable to determine beneficiary received items billed.
  - 2% Delivery ticket did not list beneficiary personal information; unable to determine beneficiary received items billed.

Items not specified in PDAC

- 85% of the denied claims were not specified in product classification list on the Pricing, Data, Analysis and Coding (PDAC) web site, which is used to verify specific items acceptable to Medicare.
  - Lumbar Sacral Orthoses are described by specific codes and are required to meet specific requirements in order for CMS to reimburse suppliers for billed items. If the items billed are unable to be located within the PDAC system; they are not recognized by CMS.

Claim Examples

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

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order. Proof of delivery, which includes date item was shipped; date item was received, beneficiary signature and invoice of items delivered. Specific information about the LSO device supplied as required through the Product Classification list on the PDAC web sites.

Missing: Clinical documentation to support medical necessity of device which includes name of beneficiary, date of appointment, and clinician's signature.

Example 2:

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

Missing: Proof of delivery, which includes date item was shipped; date item was received, beneficiary signature and invoice of items delivered. Verification about LSO device supplied through PDAC web site.

Example 3:

Received: The supplier submitted a detailed written order, which includes the beneficiaries name, specific items dispensed, treating physicians signature and date, and the start date of order. Proof of delivery, which includes date item was shipped; date item was received, beneficiary signature and invoice of items delivered. The evaluation/assessment documentation detailing the medical necessity of item(s) billed.

Missing: The submitted clinical documentation did not support the medical necessity. The documentation; to include order; was submitted from an unrecognized care provider (physical therapist) per CMS. Verification about LSO device supplied through PDAC web site.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for Lumbar-Sacral Orthoses HCPCS codes L0631 and L0637.

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

Educational References

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

- LCD for Spinal Orthoses: TLSO and LSO (L11470)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/supmandownload.aspx
  - Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/phyletters.aspx

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

Historical Review Results

A widespread complex medical review was performed for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This review resulted in a Charge Denial Rate (CDR) of 35.3%. A summary of findings was published on the NHIC Web site on October 25, 2013. Based on this result, a widespread prepayment review was continued.

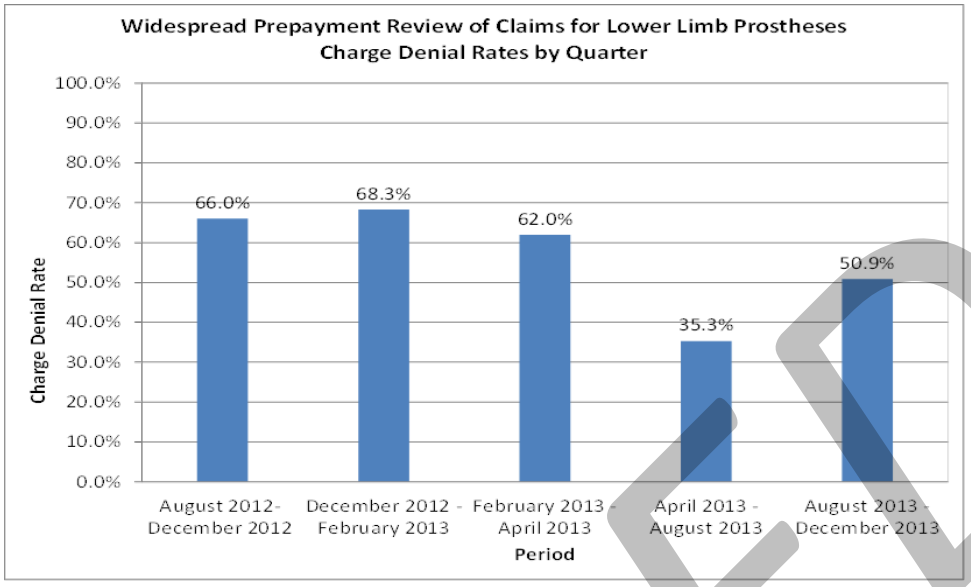
Current Review Results

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

The review involved prepayment complex medical review of 258 claims submitted by 157 suppliers for claims processed August 2013 to December 2013. Responses to the Additional Documentation Request (ADR) were not received for 21 (8%) of the claims. For the remaining 237 claims, 100 claims were allowed and 137 were denied resulting in a claim denial rate of 58%. 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 50.9%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Lack of Medical Record Documentation

- 24.8% of the denied claims had no medical record information submitted.

Evaluation/assessment documentation

- 6% of the denied claims had no prosthetist records submitted

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

- 15.6% of the denied claims had clinical records submitted but the records did not justify the functional level of the billed item.

Proof of delivery

- 5% of the denied claims were missing the proof of delivery. Proof of Delivery is 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 expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Lower Limb Prostheses claims.

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items dispensed, treating physician's signature and date, and the start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed; and the prosthetist's evaluation/assessment documentation detailing the functional levels of the items billed.

Missing: The submitted clinical documentation did not support the functional level of the device and did not corroborate the prosthetist's records. Since the prosthetist is a supplier, the prosthetist's records must be corroborated by the information in the medical record.

Example 2:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; proof of

delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed.
Missing: Clinician documentation to support functional level of device and to corroborate the prosthetist's records and the evaluation/assessment documentation for the functional level of item(s) billed.

Example 3:

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

Next Step

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

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

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

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

Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- The DME MAC Jurisdiction A *Supplier Manual* Chapter 10: Includes Standard Documentation Requirements
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/phyletters.aspx
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (Posted December 28, 2012; March 06, 2013; June 14, 2013; October 25, 2013)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Results of Widespread Prepayment Probe for Lower Limb Prostheses (Posted November 30, 2011)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces (MOB)

Historical Review Results

This is the first DME MAC A Medical Review for Group 2 Pressure Reducing Support Surfaces, HCPCS E0277. This Medical Review was initiated due to errors identified by the DME MAC A Medical Review Probe. The Group 2 Pressure Reducing Support Surfaces Probe had a charge denial rate of 59.2%, noted in the article published June 28, 2013.

Current Review Results

The DME MAC Jurisdiction A has completed the prepayment medical review of claims for Group 2 Pressure Reducing Support Surfaces, HCPCS E0277.

The review involved prepayment complex medical review of 81 claims submitted by 47 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 35 (43%) of the claims. For the remaining 46 claims, 12 claims were allowed and 34 were denied resulting in a claim denial rate of 74%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 72.3%.

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 (88%)

- 68% 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.
- 12% of the denied claims did not include medical documentation.
- 6% of the denied claims contained medical documentation that was illegible.

Detailed Written Order (24%)

- 15% of the denied claims did not include a detailed written order.
- 3% of the denied claims did not include a narrative description or a brand name/model number of the item being dispensed.
- 3% of the denied claims contained a detailed written order that was not signed by the physician.
- 3% of the denied claims contained a detailed written order that was dated after the date of service.

Proof of Delivery Issues (26%)

- 9% of the denied claims did not include proof of delivery.
- 9% of the denied claims contained proof of delivery that was not signed by the beneficiary.
- 3% of the denied claims contained proof of delivery in which the beneficiary's address could not be confirmed.
- 3% of the denied claims contained proof of delivery that contained a delivery date that was different than the date of service.
- 3% of the denied claims contained proof of delivery that was illegible.

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:
Date of Service 3/6/13

Received: The supplier submitted Medical documentation from a nurses note dated 3/5/13 and from a wound clinic dated 2/27/13; Proof of delivery dated 3/6/13 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 and date of signature that validates that the beneficiary received the items that were billed.
Missing: A detailed written order was missing from the claim submission. Also, the medical documentation indicated that the pressure ulcer on the beneficiary's sacrum/gluteal region has been resolved and the beneficiary's other pressure ulcers were not located on the trunk or pelvis. Therefore, the medical records did not provide enough information to indicate that a Group 2 support surface was reasonable and necessary.

Example 2:
Date of Service 4/14/13

Received: The supplier submitted a written order dated 5/11/13, 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 a wound care progress note dated 4/3/13 and an Occupational Therapy Discharge Summary based on an evaluation completed 1/2/13; and Proof of delivery dated 4/13/13 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 and date of 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 service. The wound care progress note dated 4/3/13 did not contain enough information to determine if 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:
Date of Service 4/17/13

Received: The supplier submitted a written order dated 4/17/13, 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; Medical documentation from a physician's visit on 3/22/13 and 4/16/13; Proof of delivery dated 4/17/13 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 and date of signature that validates that the beneficiary received the items that were billed.
Missing: The medical documentation from the visit on 3/22/13 indicates that the beneficiary has a stage I pressure ulcer on his sacrum which does not meet the coverage criteria for a Group 2 support surface: 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 clinical documentation is also dated after the date of service. Also, the medical documentation from the visit on 4/16/13 does not indicate that the beneficiary has any pressure ulcers or skin issues.

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.

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:

- LCD for Pressure Reducing Support Surfaces - Group 2 (L5068)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces
  http://www.medicarenhic.com/viewdoc.aspx?id=2311
- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/supmandownload.aspx
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- October 2012 CERT Errors
  http://www.medicarenhic.com/dme/dmerccertrec.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

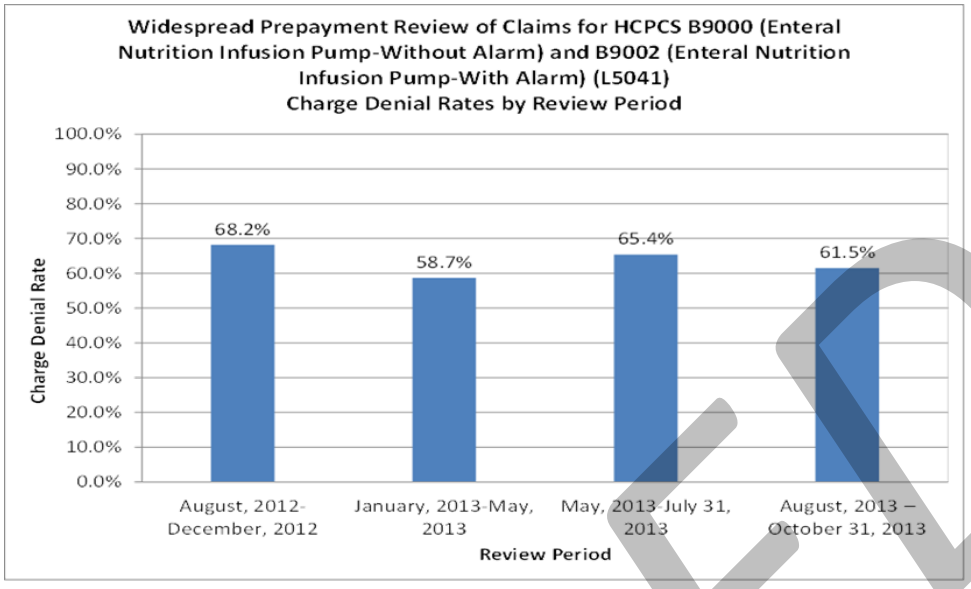
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed May 1, 2013 thru July 31, 2013 and resulted in a 65.4% 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 August 1, 2013 through October 31, 2013.

The review involved prepayment complex medical review of 1265 claims submitted by 203 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 354 (28%) of the claims. For the remaining 911 claims, 335 claims were allowed and 576 were denied/partially denied resulting in a claim denial rate of 63%. 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 61.5%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Clinical Documentation Issues

- 47% of the denied claims did not have any medical record documentation submitted.
- 15% 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 benefits requirement. Beneficiary able to take in oral nutrition.

Proof of Delivery

- 6% 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.
    - No delivery date on the delivery ticket.

Detailed Written Order Issues

- 15% of the denied claims had missing detailed written orders.
- 6% of the denied claims had incomplete detailed written orders.
    - Date of the detailed order was incomplete (missing month or year)
    - Physician's signature could not be authenticated

DME Information Form

- 7% 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: Prescribing physician detailed order, clinical notes, DIF, Delivery ticket
Missing: The delivery ticket is dated before the date of service

Example 2:

Received: Detailed physician order, clinical notes, DIF, and delivery ticket.
Missing: The date of service for the claim was after the beneficiary's demise

Example 3:

Received: Detailed physicians order, DIF, delivery ticket
Missing: Clinical notes that support reasonable and necessary use of enteral pump

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
- 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 May 2013 through July 31, 2013 and resulted in a Charge Denial Rate (CDR) of 69.8%.

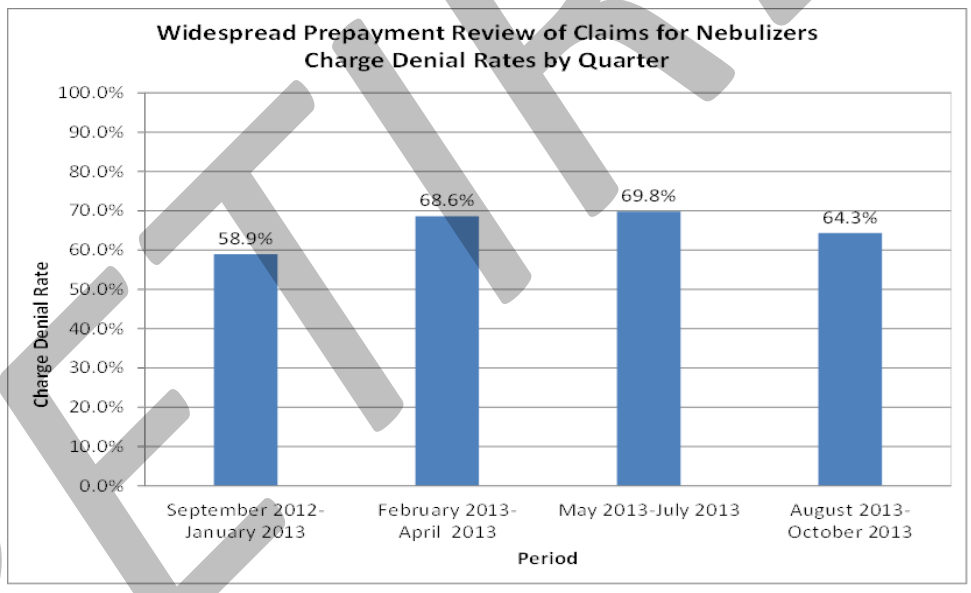
Current Review Results

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 August 1, 2013 through October 31, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 1290 claims submitted by 558 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 304 (24%) of the claims. For the remaining 986 claims, 257 claims were allowed (26%) and 729 were denied/partially denied resulting in a claim denial rate of 74%. 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 64.3%.

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

- 46% of the denied claims were missing any clinical information to support medical necessity.
  - No medical records were submitted
- 20% of the denied claims had insufficient or incomplete clinical documentation. The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer
    - Clinical documentation submitted did not list a payable diagnosis

        - Clinical documentation submitted had no mention of need for a nebulizer
    - Illegible copy of documentation submitted
    - Clinical documentation submitted was missing the Physician's signature

Detailed Written Order Issues

- 5% of the denied claims were missing the detailed written order.
- 6% of the denied claims had an incomplete or invalid detailed written order. The following are specific issues identified:
    - Illegible copy of order
    - Start date or the date of physician signature was after the date of service
    - Physician signature did not meet signature requirements including:
        - Illegible Physician signature
        - Unable to authenticate Physician signature with printed name and no signature log submitted.

Proof of Delivery Issues

- 7% of the denied claims were missing proof of delivery.
- 17% 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
    - Nebulizer(first month rental) shipped after the date of service when the item(s) is shipped via a shipping service or delivery service 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 order, proof of delivery with: beneficiary name and address, description of item to be delivered.
Missing: Illegible copy of order submitted. No clinical notes to support reasonable and necessary use of a nebulizer. In instances where the nebulizer and supplies are delivered directly by the supplier, the proof of delivery must include a beneficiary signature or representative and date of signature. The proof of delivery for this claim was missing the beneficiary signature and date of signature.

Example 2:

Received: Detailed order with: beneficiary name, description of items to be dispensed, physician's legible signature, 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 3:

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

Next Step

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

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

Educational References

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

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective April 2013 (A24944)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review of Claims for E0570: posted December 06, 2012; March 15, 2013; June 28, 2013; September 13, 2013
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- 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 July 2013 through September 2013 and resulted in a 72.0% Charge Denial Rate (CDR).

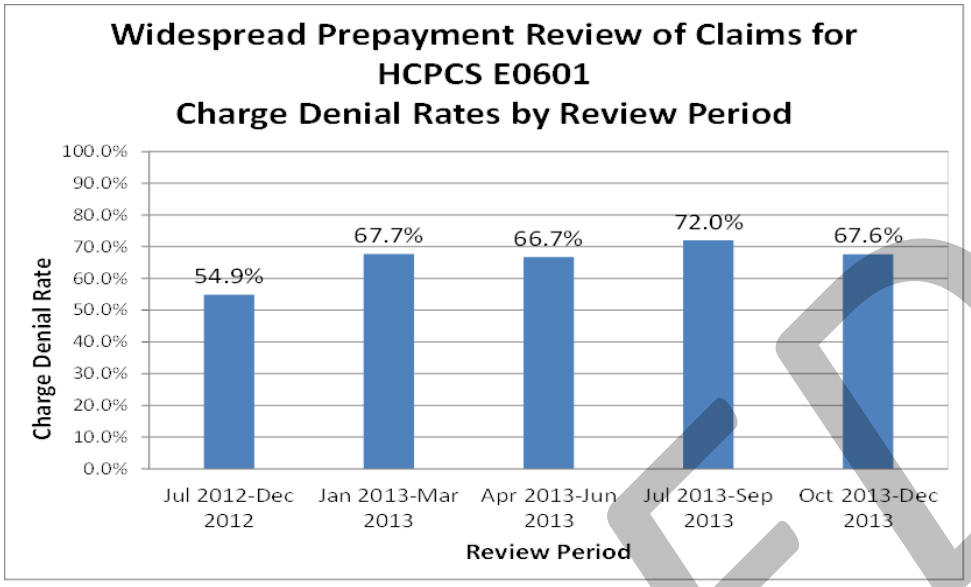
Current Review Results

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 October 2013 through December 2013. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 1458 claims submitted by 431 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 258 (17%) of the claims. Of the 1,200 claims for which responses were received, 411 claims were allowed and 789 were denied/partially denied. This resulted in a claim denial rate of 65.8%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 67.6%.

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

- 19.9% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
    - These claims had no Face-to-Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement. Scenarios included are as follows:
        A. Beneficiaries seeking initial coverage of a PAP device.
        B. Beneficiaries seeking PAP replacement following the 5 year RUL
        C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare.
        D. For continued coverage beyond the first three months of therapy.
- 24.8% 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.
- 7.6% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 1.4% of the denied claims had illegible Face-to-Face documents.

Detailed Written Order Issues

- 1.4% of the denied claims did not include the Detailed Written Order.
- 25.8% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 0.6% of the denied claims had a Detailed Written Order which was illegible.

Sleep Study Documentation Issues

- 6.8% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.

- 0.5% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 11.3% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.
- 0.5% of the denied claims had Sleep Study documents which were illegible.

Training Documentation Issues

- 23.3% of the denied claims did not include evidence of training on the PAP device.
- 5.3% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face-to-face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 4.4% of the denied claims were missing Proof of Delivery.
- 11.5% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature and date of signature.
- 1.9% of the denied claims were delivered after the Date of Service.
- 3.2% 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, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The Proof of Delivery is dated after the Date of Service.

Example 2:

Received: Included in this claim are a Detailed Written Order, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: There is no Face-to-Face clinical evaluation submitted from the beneficiary's medical record containing a detailed narrative in 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 3:

Received: Included in this claim for a beneficiary seeking replacement upon entering into Fee-for-Service (FFS) Medicare are a Face-to-Face clinical evaluation, a Detailed Written Order, Proof of Delivery, and evidence of training on the PAP device.
Missing: A Medicare approved Sleep Study from prior to enrollment in Fee-for-Service (FFS) Medicare.

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 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 (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faqs.aspx?categories=DME

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

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from April 1, 2013 through June 30, 2013 and resulted in an 82.8% Charge Denial Rate (CDR).

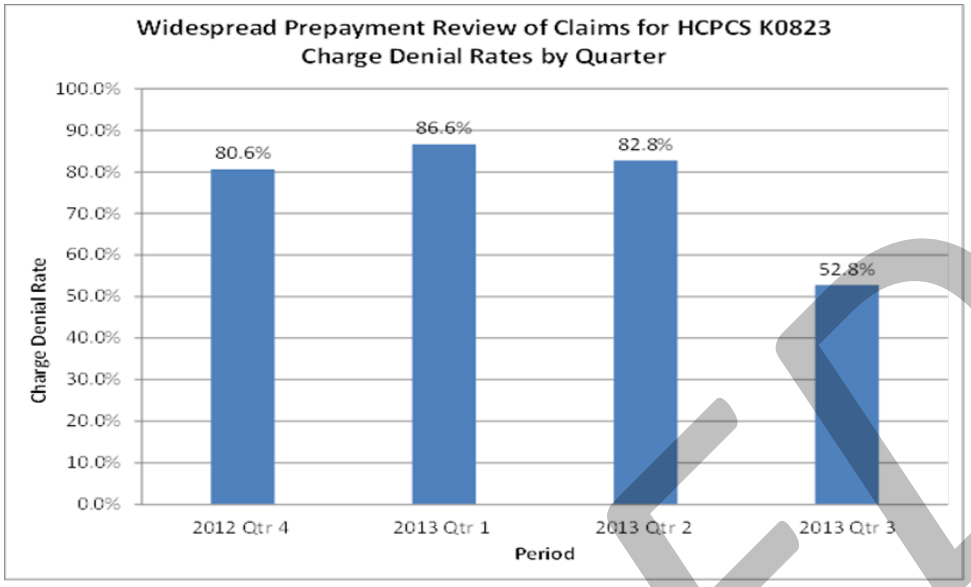
Current Review Results

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 July 1, 2013 through September 30, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 333 claims submitted by 132 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 79 (23%) of the ADR requests issued. Of the 254 claims for which responses were received, 98 of the claims were allowed and 156 of the claims were denied. This resulted in a claim denial rate of 61%. 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 52.8%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Face-to-Face Examination Issues 56.3%

32.7% of the denied claims that did not demonstrate that a K0823 is reasonable and necessary include the following issues:

- The Face-to-Face Examination did not contain a comprehensive mobility examination.
- The Face-to-Face Examination was a supplier generated form with insufficient information regarding the beneficiary's specific mobility limitations to support med necessity for a power wheelchair.
- The Face-to-Face Examination does not specify the beneficiary's mobility limitations that would establish significant impairment to participate in mobility-related activities of daily living (MRADLs) or did not indicate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- The Face-to-Face Examination does not indicate that the use of a power operated vehicle (POV) has been excluded.
- The Face-to-Face Examination did not specify objective measurements of the beneficiary's limitations for performing mobility related activities of daily living.
- The Face-to-Face Examination contains conflicting information.

23.6% of the denied claims include incomplete or missing documentation that include the following:

- The physician who completed the Face-to-Face Examination was different than the physician who signed the 7-element order.
- The Face-to-Face Examination contained corrections/changes that do not comply with record keeping principles. The face-to-face contained an addendum that did not clearly and permanently identify any alteration or addition; clearly indicate the date and author of any alteration or addition; and/or clearly identify all original content.
- The Face-to-Face Examination was missing a physician signature and/or signature date.
- The Face-to-Face Examination was missing a stamp date (or equivalent).
- The Face-to-Face Examination was illegible.
- The Face-to-Face Examination was not received within 45 days of the completion of the face-to-face.

7-Element Order Issues 19.3%

- The 7-Element Order was missing the length of need, date of face-to-face, pertinent diagnoses/conditions or had an incorrect date of the face-to-face.
- The 7-Element Order contained elements that were pre-filled or not filled out by the ordering physician.
- The 7-Element Order was not received within 45 days of the completion of the face-to-face.
- The 7-Element Order was missing a stamp date (or equivalent).

Detailed Product Description Issues (DPD) (20.1%)

- The DPD was missing.
- The DPD was missing the manufacturer name/make/model of the power wheelchair, physician's signature and/or signature date.
- The DPD was dated prior to the completion of the 7-element order.
- The DPD was missing a stamp date (or equivalent).

Proof of Delivery Issues (13.8%)

- The documentation did not contain Proof of Delivery.
- The Proof of Delivery was missing the beneficiary's signature and/or signature date.
- The items delivered did not match the items ordered on the DPD/or items billed on the ADS Letter.
- The delivery date did not match the date of service.

LCMP Examination issues (28.7%)

- The LCMP Examination is missing the physician's concurrence/disagreement with the PT/OT evaluation.
- The LCMP Examination was missing the date of evaluation.
- The LCMP Examination was missing the PT/OT signature and/or signature date or the physician's signature and/or signature date.
- The LCMP Examination was missing a stamp date (or equivalent).
- The documentation was missing a financial attestation.

Home Assessment Issues (13.4%)

- The documentation did not contain a Home Assessment.
- The Home Assessment did not demonstrate that the beneficiary's home was wheelchair accessible
- The Home Assessment was missing the supplier's signature.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

Example 1

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Examination and Home Assessment.

Missing: The 7-Element Order did not include the length of need or date of the Face-to-Face. The 7-Element Order and Face-to-Face 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 Examination as verified with a date stamp or equivalent from the supplier. The documentation submitted did not contain a DPD or Proof of Delivery.

Example 2

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Examination, Detailed Product Description, Home Assessment and Proof of Delivery.

Missing: The Face-to-Face Examination and 7-Element Order were not received by the supplier within 45 days of the completion of the Face-to-Face Examination. The Face-to-Face Examination was completed on a supplier generated form with insufficient information regarding the beneficiary's specific mobility limitations to support med necessity for power wheelchair and 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. The Detailed Product Description did not include confirmation that the supplier received a copy as verified with a date stamp or equivalent from the supplier.

Example 3

Received: Documentation provided in this claim included: the 7-Element Order, Face-to-Face Examination, LCMP Examination, Detailed Product Description, Home Assessment and the Proof of Delivery.

Missing: The Face-to-Face Examination and 7-Element Order were not received by the supplier within 45 days of the completion of the Face-to-Face Examination. The Face-to-Face Examination does not indicate that the use of a power operated vehicle (POV) has been excluded. 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. 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.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS K0823.

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

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

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

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

Educational References

NHIC Corp. DME MAC and CMS provide extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Power Mobility Devices (L21271) LCD
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Power Mobility Devices - 7-Element Order (published 11/05/2009)
  http://www.medicarenhic.com/viewdoc.aspx?id=560
- Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios (published 04/05/2013)
  http://www.medicarenhic.com/viewdoc.aspx?id=1591
- Power Mobility Devices Billing Reminder (published 01/11/2008)
  http://www.medicarenhic.com/viewdoc.aspx?id=206
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (published 09/20/2013, 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 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

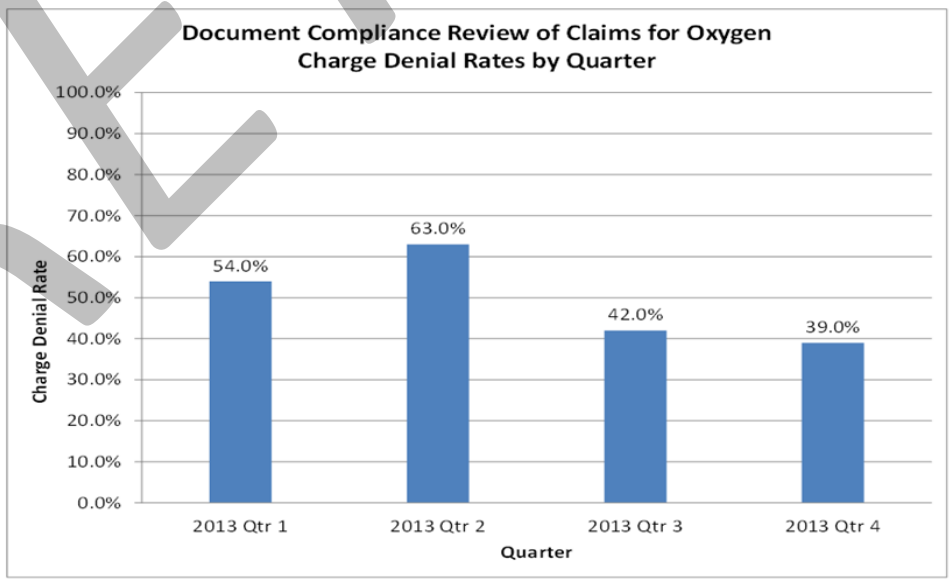
Current Review Results

These findings are for claims processed from October 01, 2013 through December 31, 2013:

- The review involved DCRs of 2,711 claims (including reopenings)
- Of the 2,711 claims reviewed, 1,063 claims were denied resulting in a claim denial rate of 39%
- An additional 155 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR)

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.
- 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/dme/mrbulletinpca.aspx
- 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 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 June 01, 2013 through September 30, 2013 and resulted in a 54.4% Charge Denial Rate (CDR).

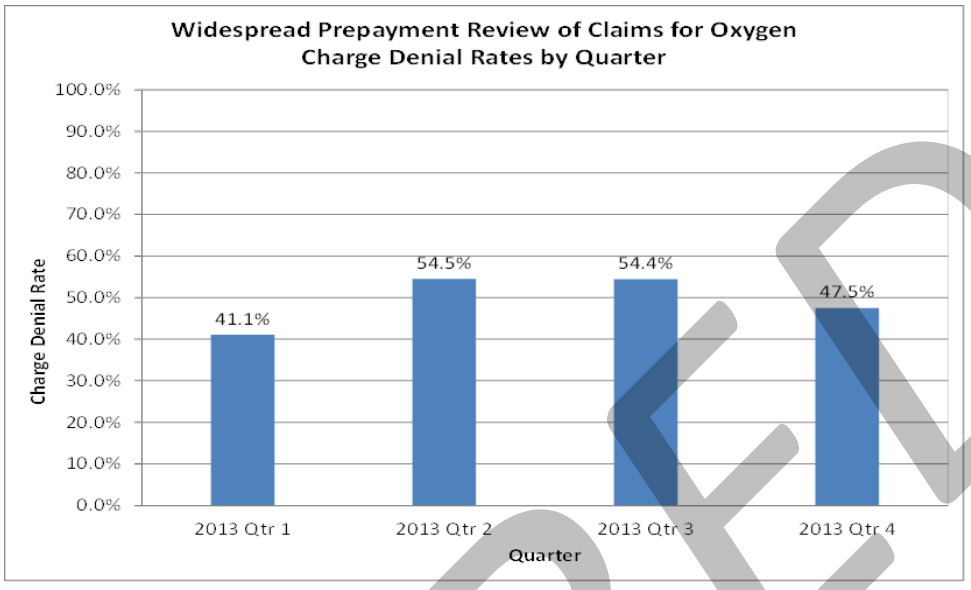
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from October 01, 2013 through December 31, 2013.

The review involved prepayment complex medical review of 269 claims submitted by 89 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 19 (7%) of the claims. For the remaining 250 claims, 148 claims were allowed and 102 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 47.5%.

Charge Denial Rate Historical Data

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



The Indications and Limitation of Coverage and/or Medical Necessity section of the Oxygen and Oxygen supplies LCD states:

Home oxygen is covered only when both the reasonable and necessary criteria are met. Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and

2. The patient's blood gas study meets the criteria stated in the LCD, and

3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and

4. The qualifying blood gas study was obtained under the following conditions:
   a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   b. If the qualifying blood gas study is not performed during an inpatient stay, the reported test must be performed while the patient is in a chronic stable state - i.e. not during a period of acute illness or an exacerbation of their underlying disease, and

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11468 and related Policy article for additional information.

Primary Reasons for Denial

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

Missing Documentation (78%):

Missing required physician visit per Local Coverage Determination (LCD) L11468:

- 35% - Missing treating physician visit 30 days prior to the initial date of service

Missing qualifying blood gas study per LCD L11468:

- 23% - No documentation to validate oxygen testing

Missing required Certificate of Medical Necessity per LCD L11468:

- 8% - Missing an Initial CMN or Initial CMN was incomplete

Missing valid proof of delivery per LCD L11468:

- 12% - Missing valid delivery ticket

Clinical Documentation Issues: Medical Necessity could not be established (22%):

Clinical documentation did not support criteria of LCD L11468 for the following reasons (17%):

- No indication in medical documentation of presence of severe lung disease or hypoxia related symptoms
- Medical documentation does not demonstrate that beneficiary was tested in a chronic stable state
- Signature requirements were not met
- Documentation submitted was illegible
- Missing documentation of polysomnograph testing for patient with obstructive sleep apnea (OSA)

Clinical documentation did not support criteria indicated on CMN for the following reasons (5%):

- Exercise testing did not qualify for Group I testing criteria - documentation did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy
- Qualifying arterial oxygen saturation was not at or below 88%
- Saturation criteria for a flow rate greater than 4 LPM was not met

Claim Examples

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

Example 1: DOS 11/14/13
Code(s) Billed: E1390, E0431

Documentation Received: Complete written order signed and dated 11/14/13; documentation of a physician visit dated 11/14/13; unauthenticated and undated inpatient note which includes the qualifying exercise oximetry report; initial CMN dated 11/14/13; proof of delivery dated 11/14/13
Missing: Authenticated and dated copy of the inpatient note which includes the qualifying exercise oximetry report

Example 2: DOS 4/23/13
Code(s) Billed: E1390

Documentation Received: Initial CMN dated 4/23/13, also acting as the complete written order; proof of delivery dated 4/23/13; service plan document; documentation of a physician visit dated 4/26/13, after the DOS
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 5/7/13
Code(s) Billed: E1390

Documentation Received: Documentation of a physician visit dated 5/2/13 demonstrating that the patient has a severe lung disease; progress note dated 5/22/13, after the DOS; progress note dated 4/24/13; initial CMN dated 5/7/13, also acting as the complete written order; documentation of exercise oximetry results dated 5/30/12; proof of delivery dated 6/7/12
Missing: Documentation of a blood gas study in the medical record dated prior to the initial date of service to validate the blood gas study results provided on the initial CMN; proof of delivery dated 5/7/13

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS E1390, E0431 and E0439.

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/supmandownload.aspx
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.
- CERT Error articles - Monthly publications
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- 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: 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/dme/mrbulletinpca.aspx

Join the NHIC, Corp. DME MAC A ListServe!
Visit http://www.medicarenhic.com/dme/listserve.html today!

Provider Contact Center Reminders (GEN)

The NHIC, Jurisdiction A DME MAC Provider Contact Center (PCC) is a valuable resource available to our DMEPOS customers. Customer Care Representatives (CCRs) are available to assist you with a wide-range of Medicare coverage and billing-related inquiries. CCRs strive each day to assist as many customers as possible with accurate information. You can assist in this effort by asking the CCR very clear concise questions and by being prepared to provide all necessary information needed by the CCR to answer your questions. Our PCC number is: **866-590-6731**

If you contact the PCC with an inquiry that can be addressed via the IVR you will be advised to disconnect and call the IVR for the information. The IVR toll-free number is: **866-419-9458**

Below are tips to maximize your experience when contacting the PCC.

Initially Suppliers Must Have the Following Information Available:

- NPI (the NPI number linked to your PTAN - this is not the individual doctors NPI)
- PTAN (this is your DME supplier number issued to your company by the NSC)
- TIN (the last five digits of your tax ID)

To research Claim Denials Suppliers Must Have the Following Information:

- Medicare number
- Beneficiary's Name (we require the full name including prefix or suffix for example Sr. or Jr.)
- Date of birth (this is needed for eligibility based denials)
- Denial reason (this can be obtained from your remit or by calling the IVR under claim status)
- Date of Service of claim in question

Contact the PCC during non-peak hours:

Due to high call volumes, you may experience longer wait times when contacting the PCC. Therefore, it is recommended that you try calling during non-peak hours, which is typically between 8:00a.m. - 11:00a.m. or 12:30p.m. - 2:30p.m. EST.

Remember CCRs are not able to:

- Provide claim status, beneficiary eligibility, or any other information that is available through the interactive voice response (IVR) system;
- Provide information on what modifiers, diagnosis codes, current procedural terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) to use for specific claims or beneficiaries;
- Preauthorize any type of service or supply; and
- Answer inquiries from beneficiaries or their representatives.

Suppliers should also consider using our free web based application, the Provider Services Portal (PSP) (**http://www.medicarenhic.com/dme/psphome.aspx**), as an alternative to the IVR. The Provider Services Portal (PSP) offers superior search capabilities that make it fast and easy to find the information you need without having to place calls to the PCC or IVR.

Obtaining Same and Similar Information (GEN)

Effective immediately, suppliers can contact the Jurisdiction A Provider Contact Center to obtain same and similar information for all HCPCS codes that are **not** available on the Interactive Voice Response (IVR) System **without** the beneficiary providing verbal or written authorization to a Customer Care Representative (CCR) to release the information.

This includes HCPCS codes beginning with the letters A, L, or V. Some of these items may include:

- Diabetic Supplies
- External Breast Prosthesis
- Eye Prosthesis
- Facial Prosthesis
- Knee Orthosis
- Lower Limb Prosthesis
- Orthotic Footwear
- Refractive Lenses
- Spinal Orthosis: Thoracic--Lumbar-Sacral Orthosis (TLSO) and Lumbar-Sacral Orthosis (LSO)
- Surgical Dressings
- Therapeutic Shoes for Diabetics
- Tracheotomy Supplies
- Urological Supplies
- Transcutaneous Electrical Nerve Stimulator (TENS) Supplies

Suppliers are reminded when requesting same and similar information for a specific beneficiary you must have a dispensing order on file for the particular beneficiary and item.

When contacting the Jurisdiction A Contact Center to obtain same and similar information for items that can't be obtained via the IVR system and/or the Provider Services Portal (PSP) (**http://www.medicarenhic.com/dme/psphome.aspx**), you will still need to follow the required authentication requirements. These authentication requirements include: Provider Transaction Access Number (PTAN), National Provider Identifier (NPI), and the last five digits of your Tax Identification Number (TIN). You will be allowed three attempts to correctly provide the PTAN, NPI, and the last five digits of TIN. Once you have properly entered your authentication requirements, you will also be required to provide the following beneficiary elements: beneficiary's HICN, first name or first initial of the first name, last name, and date of birth.

Note: The beneficiary's name should be exactly the same as it appears on the beneficiary's Medicare card.

The Jurisdiction A DME MAC Provider Contact Center is available from 8:00 a.m. - 5:00 p.m. ET, Monday through Friday. The toll-free number for the contact center is 866-590-6731.

Avoid Denials for Provider Enrollment, Chain and Ownership System (PECOS) Ordering/Referring Physician Edits (GEN)

Claims that fail the Ordering/Referring physician edits with dates of service on or after January 06, 2014 will be denied.

Prior to dates of service January 06, 2014 suppliers received the informational N544 message on their remittance advice for claims that failed the Ordering/Referring physician edits.

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

Medicare will only reimburse for specific items or services when those items or services are ordered by providers or suppliers authorized by Medicare statute and regulation to do so. Claims from billing providers and suppliers that are denied because they failed the Ordering/Referring edit will not expose a Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is <u>not</u> appropriate in this situation.**

If the claim did not initially pass the Ordering/Referring provider edits and is denied:

- Verify the ordering/referring information submitted was an exact match with the PECOS record.
  - If the information submitted did not match the PEOS record, correct and resubmit the claim.
  - If the exact information was submitted, file an appeal through the standard claims appeals process.

CMS has highlighted the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Optometrists may only order and refer DMEPOS products/services, and laboratory and x-ray services payable under Medicare Part B.

To avoid claim denials

1. Confirm the provider is a specialty that can order DMEPOS. The following is a list of those eligible to order and refer items/services for Medicare beneficiaries:
   - Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
   - Physician Assistants,
   - Clinical Nurse Specialists,
   - Nurse Practitioners,
   - Clinical Psychologists,
   - Interns, Residents, and Fellows,
   - Certified Nurse Midwives, and
   - Clinical Social Workers.

2. Verify that the ordering physician's National Provider Identifier (NPI) is on the list of physicians and other non-physician practitioners enrolled in PECOS. This can be done by:
   a. Checking the **CMS ordering/referring provider downloadable report** which contains the NPI, first name, and last name of providers enrolled in PECOS located on the CMS Web site at: **http://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html**
   b. Calling the NHIC, Corp. DME MAC IVR, 866-419-9458 and select Option 8; enter the NPI, first and last name of the referring provider. The IVR will respond if the individual is or is not enrolled in PECOS.

3. Ensure that the Ordering/Referring Provider's name is entered correctly on the claim. The edits will compare the first four letters of the last name.
   - Do not use "nicknames" on the claim, as this could cause the claim to fail the edits.
   - Do not enter a credential (e.g., "Dr.") in a name field.
   - On paper claims (CMS-1500), enter the ordering provider's first name first, and last name second (e.g., John Smith), in Item 17 and only include the first and last name as it appears on the ordering and referring file.
   - Ensure that the name and the NPI for the ordering provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non- physician practitioner who generated the order.
   - On electronic claims, ensure that you are not submitting the last name in the first name field and vice versa.
   - Confirm the ordering physician's name is spelled correctly as listed in the PECOS listing and that the qualifier in the 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

Example:

The following are examples which would fail the PECOS ordering/referring physician edits. The table includes the physician's name as submitted by the supplier, the physician's name on the PECOS file, the four characters of the last name the DME MAC would be comparing and the 4 characters of the last name as listed in the PECOS file.

In the first example, the supplier submitted the ordering physician's name as MACIE DE LUNA; the name is listed as MACIE DELUNA in the PECOS file. This claims would fail the edits due to the first four letters on the last name submitted on the claim does not match the first four letters of the last name in the PECOS file.

Supplier Submitted	PECOS File	Last Name: 4 Character Match - DME MAC	Last Name: 4 Character Match - PECOS
MACIE DE LUNA	MACIE DELUNA	DE L	DELU
JANE TAM PARRO	JANE PARRO	TAM	PARR
BRIANNE TAPAS	BRIANNE TAPES	TAPA	TAPE
LEE KYING	KYING LEE	KYIN	LEE

Top Ordering/Referring Submission Errors

- Supplier interchanging first and last name of referring physician
- Supplier submitting the organizational NPI of referring physician
- Nurse Practitioners/Interns not enrolled in Medicare
- Supplier submitted last name not matching PECOS

Additional information is available at:

- *Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)* (SE1305) located at: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/Downloads/SE1305.pdf**

- The PECOS Highlights & Headlines Page at: **http://www.medicarenhic.com/dme/dmepecos.aspx**

Fourth Quarter 2013 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for October through December 2013 are provided in the following table.

Note: *The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.*

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 - Rejected for relational field Information within the HCPCS	101,105	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.094.2010AA.REF02.050 - Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	26,067	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.121.2010BA.NM109.020 - Invalid Information for a Subscriber's contract/member number	22,324	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	18,289	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.
X222.401.2400.REF02.070 - This Claim is rejected for invalid information within the Line Item Control Number	14,599	Line Item Control Number must be unique within a single iteration of 2300.CLM01.
X222.380.2400.DTP03.090 - Invalid Information within the Date(s) of service	12,302	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.380.2400.DTP03.080 - Invalid Information within the Future date and Date(s) of service	11,657	The service start/from date is greater than the date this claim was received.
X222.087.2010AA.NM109.030 - Invalid information in the Billing Provider's NPI	10,740	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.351.2400.SV101-3.020 - This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	9,565	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.226.2300.HI01-2.030 - Invalid Information within the Primary diagnosis code	8,870	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.

Fourth Quarter 2013 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the fourth quarter of 2013. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from October through December 2013.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	30,893
OA109, N104 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	12,596
CO 182, N56 Procedure modifier was invalid on the date of service	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	10,770
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.	4,996
CO 172, M143 The provider must update license information with the payer.	Payment is adjusted when performed/billed by a provider of this specialty.	2,916
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).	1,862
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.	1,673

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16, M79 Missing/incomplete/invalid charge.	**Item 24F** - Did not complete or enter the appropriate charge for each listed service (submitted charges zero).	1,647
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.	1,595
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.	1,439

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 December 2013 chapters 1, 2, 4, 8, 10, and 12 of the *DME MAC A Supplier Manual* were updated. In January 2014 chapter 3 of the *DME MAC A Supplier Manual* was 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**

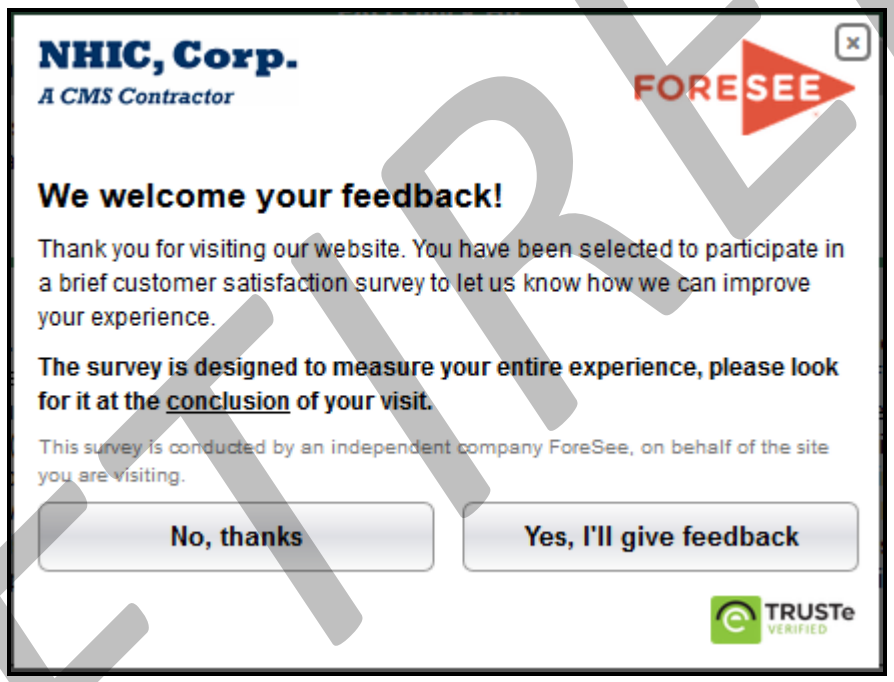
DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

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!



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 the DME MAC A PSP Home page.

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

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Reconsiderations:
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:
NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:
Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: **ngs.CEDIHelpdesk@wellpoint.com**

DME MAC Jurisdiction A Resource

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

March 2014
Number 31

Publication Information

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

Visit the following websites for more information:

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

TriCenturion: www.tricenturion.com

CMS: www.cms.gov

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

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

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

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
Hingham, MA 02043