DME MAC Jurisdiction A Resource

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

September 2014
Number 33

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/

General Information

Claim Status Category and Claim Status Codes Update (MM8735) (GEN) 4

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE (MM8838) (GEN) 5

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - July 1, 2014 Version 3.1.1 (MM8711) (GEN) 6

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM8855) (GEN) 7

How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database (SE1421) (GEN) 10

International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers (MM8858) (GEN) 12

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) 13

Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach (SE1409) (GEN) 17

Partial Code Freeze Prior to ICD-10 Implementation (SE1240) (GEN) 19

Clarification of Billing Instructions Related to the Home Health Benefit (MM8775) (GEN) 21

Competitive Bidding Program (CBP): Correction to VIPS Medicare System (VMS) Processing of Wheelchair Accessory Claims for Round 2 (MM8864) (MOB) 22

DMEPOS Competitive Bidding Round 2 Recompete and National Mail-Order Recompete Announced (GEN) 24

Fingerprint-based Background Check Begins August 6, 2014 (SE1427) (GEN) 26

Healthcare Provider Taxonomy Codes (HPTC) Update, October 2014 (MM8866) (GEN) 27

Intravenous Immune Globulin (IVIG) Demonstration - Implementation (SE1424) (SPE) 28

Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims (MM8401) (GEN) 32

Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs) (SE1231) (MOB) 33

Medicare Remit Easy Print (MREP) Enhancement (MM8856) (GEN) 36

Medicare Signature Requirements - Educational Resources for Health Care Professionals (SE1419) (GEN)... 37

New Physician Specialty Code for Interventional Cardiology (MM8812) (SPE) 39

October 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8836) (DRU) 40

October Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8865) (GEN) 41

Revised Modification to the Medically Unlikely Edit (MUE) Program (MM8853) (GEN) 42

Two New “K” Codes for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS) (MM8839) (O&P) 44

Table of Contents

Fee Schedule Updates (GEN) 45

First Level Appeal requests now accepted via esMD (GEN) 46

CMS News Flash (GEN) 46

MLN Connects™ Provider eNews (GEN) 48

Medical Review

ACA 6407 Requirements - Corrections and Amendments to the Face-to-Face Visit and Written Order Prior to Delivery (WOPD) - Joint DME MAC Publication (GEN) 58

Ankle-Foot Orthoses: Walking Boots - Coverage and Coding Issues – Revised (O&P) 59

Correct Coding - Billing Of HCPCS Code E0986 (MOB) 59

Correct Coding - Palatal Lift Prosthesis - Joint DME MAC Publication (GEN) 59

Correct Coding - Vibration Therapy Devices - Joint DME MAC Publication (GEN) 60

Coverage and Correct Coding of Continuous Glucose Monitoring Devices - Joint DME MAC Publication (SPE) 60

Coverage Reminder - Speech Generating Devices - Joint DME MAC Publication (SPE) 61

Electronic Health Records and Addenda - July 2014 (GEN) 62

Electronic Health Records and Addenda - Joint DME MAC Publication (GEN) 63

Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding – Revised - Joint DME MAC Publication (SPE) 64

Home Oxygen Initial Qualification Testing – Revised - June 2014 (OXY) 68

LCD and Policy Article Revisions Summary for July 24, 2014 (GEN) 69

LCD and Policy Article Revisions Summary for June 19, 2014 (GEN) 70

LCD and Policy Article Summary for June 12, 2014 - Drafts Released to Final (GEN) 70

Orthoses/Prostheses - Coding for Professional Services/Fabrication Supplies (O&P) 71

Orthoses: Replacement of Components Clarification (O&P) 71

Policy Reminder - Positive Airway Pressure (PAP) Devices - Continued Coverage beyond the First Three Months of Therapy - Joint DME MAC Publication (SPE) 72

Positive Airway Pressure Device and Respiratory Assist Device - Nasal Interfaces and Liners – Revised (SPE) 73

Proof of Delivery - Requirements for Signature and Date - Joint DME MAC Publication (GEN) 74

Reminder - Oxygen Equipment and Contents Delivery (OXY) 74

Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (O&P) 74

Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (PEN) 77

Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (SPE) 79

Results of Widespread Prepayment Review of Claims for L0631 and L0637, Lumbar-Sacral Orthoses (L11470) (O&P) 82

Supplier Exit from Oxygen Equipment Business – Revised - Joint DME MAC Publication (OXY) 84

Vacuum Erection Device - Coding Verification Review Requirement (O&P) 86

Widespread Prepayment Probe for HCPCS Code E0464 (Pressure Support Ventilator with Volume Control Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (e.g. Mask)) (SPE) 86

Outreach & Education

Reopening and Redetermination Submission & Status - Now Available on our Provider Services Portal (PSP) (GEN) 88

Table of Contents

Provider Services Portal (PSP) Announcement - New Functionality Added (GEN) 88
Second Quarter 2014 - Top Claim Submission Errors (GEN) 89
Second Quarter 2014 - Top Return/Reject Denials (GEN) 89
Supplier Manual News (GEN) 90
Quarterly Provider Update (GEN) 91
Updating Supplier Records (GEN) 91
DME MAC A ListServes (GEN) 91
DME MAC Jurisdiction A Web Site Customer Satisfaction Survey 92

Legend

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

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

Claim Status Category and Claim Status Codes Update (MM8735) (GEN)

MLN Matters® Number: MM8735
Related CR Release Date: August 22, 2014
Related CR Transmittal #: R3043CP
Related Change Request (CR) #: CR 8735
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (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 Change Request (CR) 8735 which informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure your billing staffs are aware of these changes.

Background

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

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the September/October 2014 committee meeting shall be posted on that site on or about November 1, 2014. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8735.

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 8735.

All MACs must comply with the requirements contained in the versions 004010X093A1 and 005010X212 of ASC X12 276/277 Implementation Guide as well as the 005101X214 of the ASC X12 277 Health Care Claim Acknowledgement Implementation Guide (inclusive of any published Errata documents) and must use valid Claim Status Category Codes and Claim Status Codes when sending 277 responses.

Additional Information

The official instruction, CR 8735 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3043CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE (MM8838) (GEN)

MLN Matters® Number: MM8838
Related CR Release Date: August 22, 2014
Related CR Transmittal #: R3038CP

Related Change Request (CR) #: CR 8838
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8838 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2014. This update is based on July 1, 2014 CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014 under the Patient Protection and *Affordable Care Act* of 2010. The *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) amended the *Social Security Act* by adding Part C - Administrative Simplification - to Title XI of the *Social Security Act*, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

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

Additional Information

The official instruction, CR8838 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3038CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - July 1, 2014 Version 3.1.1 (MM8711) (GEN)

MLN Matters® Number: MM8711 Revised
Related CR Release Date: August 8, 2014
Related CR Transmittal #: R1418OTN

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

Note: *This article was revised on August 12, 2014, to reflect the revised CR8711 issued on August 8, 2014. The CR revised the CAQH CORE version number and the publication date. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same.*

Provider Types Affected

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

What You Need to Know

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

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the *Affordable Care Act*.

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

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

CAQH CORE will publish the next version of the Code Combination List on or about July 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit http://www.wpc-edi.com/ reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.)

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

Additional Information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1418OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work?

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM8855) (GEN)

MLN Matters® Number: MM8855
Related CR Release Date: July 24, 2014
Related CR Transmittal #: R2996CP
Related Change Request (CR) #: CR 8855
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8855 instructs the MACs to make programming changes to incorporate updates to the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use that software.

Background

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

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets, CARC and RARC, that must be used along with a Group Code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information. If there is any adjustment, the appropriate Group Code must be reported. Additionally, for transaction 837 Coordination of Benefits (COB), CARC and RARC must be used. CARC and RARC code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met.

MACs must make the necessary CARC/RARC code list updates on a regular basis. Any modification and/or deactivation, even if not initiated by Medicare, will be implemented.

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. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. 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 another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare has the responsibility to implement code deactivation (making sure that any deactivated code is not used in original business messages), but the deactivated code in derivative messages is allowed. Medicare must be sure to not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR8855, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 8855 lists only the changes that have been approved since the last code update CR (CR 8703, Transmittal 2920, issued on April 4, 2014; see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8703.pdf on the CMS website), and does not provide a complete list of codes for these two code sets. The MACs must get the complete list for both CARC and RARC from the WPC website that is updated three times a year (around March 1, July 1, and November 1) to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts Remittance Advice code use.

You can find the WPC website, which has four listings available for both CARC and RARC, at http://www.wpc-edi.com/Reference on the Internet.

Changes in CARC List since CR 8703

The following tables list the changes in the CARC database since the last code update in CR8703. The full CARC list is available from the WPC website at http://wpc-edi.com/ Reference on the Internet.

New Codes - CARC:

Code	Modified Narrative	Effective Date
261	The procedure or service is inconsistent with the patient's history.	06/01/2014

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
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) ***Notes: Not for use by Workers' Compensation payers; use code P3 instead.*** ***CMS Note: This code was previously deactivated, however it is being reactivated.***	06/01/2014
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the National Council of Prescription Drugs Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/01/2014
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/01/2014
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) ***Notes: To be used after the first month of the grace period.***	06/01/2014

Deactivated Codes - CARC: None

Changes in RARC List since CR 8703

The following tables list the changes in the RARC database since the last code update in CR8703. The full RARC list is available from the WPC website at http://wpc-edi.com/Reference on the Internet.

New Codes - RARC: None

Modified Codes - RARC:

Code	Modified Narrative	Effective Date
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	07/01/2014
M77	Missing/incomplete/invalid/inappropriate place of service.	03/14/2014
M84	Medical code sets used must be the codes in effect at the time of service.	03/14/2014
MA100	Missing/incomplete/invalid date of current illness or symptoms.	03/14/2014
N202	Additional information/explanation will be sent separately.	03/14/2014
N203	Missing/incomplete/invalid anesthesia time/units.	03/14/2014
N205	Information provided was illegible.	03/14/2014
N208	Missing/incomplete/invalid DRG code.	03/14/2014
N210	Alert: You may appeal this decision.	03/14/2014
N211	Alert: You may not appeal this decision.	03/14/2014
N212	Charges processed under a Point of Service benefit.	03/14/2014
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	03/14/2014
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	03/14/2014
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	03/14/2014
N217	We pay only one site of service per provider per claim.	03/14/2014
N238	Incomplete/invalid physician certified plan of care.	03/14/2014
N245	Incomplete/invalid plan information for other insurance.	03/14/2014
N354	Incomplete/invalid invoice.	03/14/2014
N388	Missing/incomplete/invalid prescription number.	03/14/2014
N433	Resubmit this claim using only your National Provider Identifier (NPI).	03/14/2014
N438	This jurisdiction only accepts paper claims.	03/14/2014
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	03/14/2014
N467	Missing Tests and Analysis Report.	03/14/2014
N474	Incomplete/invalid certification.	03/14/2014
N476	Incomplete/invalid completed referral form.	03/14/2014
N478	Incomplete/invalid Dental Models.	03/14/2014
N482	Incomplete/invalid Models.	03/14/2014
N484	Incomplete/invalid Periodontal Charts.	03/14/2014
N488	Incomplete/invalid Prosthetics or Orthotics Certification.	03/14/2014
N490	Incomplete/invalid referral form.	03/14/2014
N543	Incomplete/invalid income verification.	03/14/2014
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.	03/14/2014

Code	Modified Narrative	Effective Date
N554	Missing/Incomplete/Invalid Family Planning Indicator.	03/14/2014
N570	Missing/incomplete/invalid credentialing data.	03/14/2014
N609	80% of the provider's billed amount is being recommended for payment according to Act 6.	03/14/2014
N645	Mark-up allowance.	03/14/2014
N667	Missing prescription.	03/14/2014
N668	Incomplete/invalid prescription.	03/14/2014
N687	Alert: This reversal is due to a retroactive disenrollment.	03/14/2014
N688	Alert: This reversal is due to a medical or utilization review decision.	03/14/2014
N689	Alert: This reversal is due to a retroactive rate change.	03/14/2014
N690	Alert: This reversal is due to a provider submitted appeal.	03/14/2014
N691	Alert: This reversal is due to a patient submitted appeal.	03/14/2014
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.	03/14/2014
N693	Alert: This reversal is due to a cancellation of the claim by the provider.	03/14/2014
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.	03/14/2014
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.	03/14/2014
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.	03/14/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	03/14/2014

Deactivated Codes - RARC: None

Additional Information

The official instruction, CR 8855 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2996CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database (SE1421) (GEN)

MLN Matters® Number: SE1421 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 August 4, 2014, to show the new ICD-10 implementation date of October 1, 2015. All other information is unchanged.*

Provider Types Affected

This article is intended for all physicians, providers, and suppliers who submit 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

This MLN Matters® Special Edition article is intended to convey information on how to access updates to International Classification of Diseases, 10th Edition (ICD-10) Local Coverage Determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD).

Background

MACs may develop an LCD to further define a National Coverage Determination (NCD) or in the absence of a specific NCD. An LCD is a coverage decision made at a MAC's own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that can assist you in submitting correct claims for payment by:

- Outlining coverage criteria;
- Defining medical necessity; and
- Providing references upon which a policy (LCD) is based and codes that describe covered and/or noncovered services when the codes are integral to the discussion of medical necessity.

The MCD

To access the CMS MCD, visit http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx on the CMS website.

Use the following steps to access the list of LCDs with ICD-10 codes:

1. **On the CMS MCD Homepage, click on the "Indexes" tab at the top of the page;**
2. **Select "Local Coverage";**
3. **Select one of the three display options for LCDs ("LCDs by Contractor," "LCDs by State," or "LCDs Listed Alphabetically");**
4. **If you choose LCDs by Contractor, click on that link;**
5. **Select a MAC;**
6. **In the Document types, checkmark the square for "Future LCDs/Future Contract Number LCDs";**
7. **Click the "Submit" button;**
8. **Click on the Contractor name; and**
9. **A list of Future Effective LCDs will display. Those LCDs with a 10/01/2015 Effective Date are ICD-10 LCDs.**

Notes:

1. The ICD-10 updates are labeled "future" as the policies are not yet in effect. These updates are subject to change as necessitated by code updates and policy revisions.
2. The 10/01/2014 Effective Dates were changed to 10/01/2015 in August 2014.

Printing Documents on the CMS MCD

All documents on the CMS MCD may be printed. Use the following steps to print a document:

1. Open the document; and
2. In the upper right-hand corner, click on the "Print" button or use "Control + P". Alternatively, click on the "Need a PDF?" button and click on the "Save a Copy" icon on the bottom of your screen or use "Shift + Control + S".

Additional Information

For an in-depth review on how to use the CMS MCD, refer to the Medicare Learning Network® publication titled "How to Use the Medicare Coverage Database" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareCvrgeDatabase_ICN901346.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers (MM8858) (GEN)

MLN Matters® Number: MM8858
Related CR Release Date: August 22, 2014
Related CR Transmittal #: R1423OTN

Related Change Request (CR) #: CR 8858
Effective Date: 30 Days From Issuance (See test dates)
Implementation Date: November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week;

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR8858 instructs all MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor to promote ICD-10 Acknowledgement Testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17 - 21, 2014
- March 2 - 6, 2015
- June 1 - 5, 2015

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 *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have 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.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.

- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional Information

The official instruction, CR8858 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1423OTN.pdf on the CMS website. The EDI help desk numbers for institutional claim submitters are available at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf on the CMS website and the numbers for professional claims submitters are available at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf 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 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 7492
Effective Date: October 1, 2015
Implementation Date: N/A

Note: *This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.*

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, 2015, 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, 2015. 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, 2015, 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, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, 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, 2015, 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, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, 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, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, 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, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, 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, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, 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, 2015. 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 10/1/15, 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, 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**

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
		through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	
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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 10/1/2015, 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 10/1/2015.	***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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
73X	Federally Qualified Health Clinics *(prior to 4/1/10)*	N/A - Always ICD-9 code set.	**N/A**
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and	**FROM**

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
		later.	
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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 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 10/1/2015, 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 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 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 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of	**FROM**

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
	service occurs after 10/1/2015).	

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, 2015. You may also want to review SE1410 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

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, 2015
Implementation Date: N/A

Note: *This article was revised on July 31, 2014, to show the new ICD-10 implementation date of October 1, 2015. In addition, the portions of the article that discuss ICD-10 acknowledgement testing and end-to-end testing are updated as a result of the new implementation date.*

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, 2015, 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 International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. 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 ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the 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 4 weeks;
- 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) and Local Coverage Determination (LCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs and LCDs 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

- 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 the near future.

Acknowledgement Testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows 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.

MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

End-to-End Testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare 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 shortly. Volunteer submitters will be selected nationwide to participate in the end-to-end testing. The 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.

Claims Submission Alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance. Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work. In addition to showing the toll-free numbers, you will find your MAC's website address at this site in the event you want more information on the free billing software or the MAC's provider internet portals mentioned above.

Partial Code Freeze Prior to ICD-10 Implementation (SE1240) (GEN)

MLN Matters® Number: SE1240 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 August 1, 2014, to make changes as a result of the delay of ICD-10 implementation until October 1, 2015.*

Provider Types Affected

This MLN Matters® Special Edition Article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know

At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2014 to October 1, 2015 by final rule CMS-0043-F issued on July 31, 2014. This final rule is available at https://www.federalregister.gov/articles/2014/08/04/2014-18347/change-to-the-compliance-date-for-the-international-classification-of-diseases-10th-revision on the Internet.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012, October 1, 2013, and October 1, 2014, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.

- On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. No further updates will be made to ICD-9-CM on or after October 1, 2015, as it will no longer be used for reporting; and
- On October 1, 2016, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_Morning_Transcript' file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to:
http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_ICD9_Meeting_Summary_report.pdf' file. Information on the Code Freeze begins on page 5.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page** - This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/Medicare/Coding/ICD10/index.html and check back regularly for access to ICD-10 implementation information of importance to you. **Note:** *Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.*

- **CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

- **See MLN Matters® Special Edition Article, SE1239, at** http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf for an overview of what is needed to implement ICD-10.

- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/Medicare/Coding/ICD10/index.html, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI)** http://www.wedi.org; and
- **Health Information and Management Systems Society (HIMSS)** http://www.himss.org/icd10 on the Internet.

Clarification of Billing Instructions Related to the Home Health Benefit (MM8775) (GEN)

MLN Matters® Number: MM8775
Related CR Release Date: June 20, 2014

Related CR Transmittal #: R2977CP

Related Change Request (CR) #: CR 8775
Effective Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10
Implementation Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10

Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and suppliers of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed

This article is based on Change Request (CR) 8775, which updates the "*Medicare Claims Processing Manual,*" to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

Background

CR 8775 makes a variety of small changes to the "*Medicare Claims Processing Manual*". These changes do not reflect any new policy. These changes fall into one of three categories.

1. Clarification to Home Health Consolidated Billing (HH CB) Instructions: In 2003, CR 2705 made changes to Medicare systems to bypass services from Home Health Consolidated Billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the "*Medicare Claims Processing Manual*". CR8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR8775, and you will find a link to that CR in the "Additional Information" section of this article.

2. Removal of References to the Home Health Advance Beneficiary Notice (HHABN): CR 8404 described the use of the Advance Beneficiary Notice of Noncoverage (ABN) as a replacement for the HH ABN. CR8775 makes conforming changes to Chapter 10 to remove references to the HHABN.

3. Conforming to National Standards: CR8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee's *Official UB-04 Data Specifications Manual*. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

Note: *MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.*

Additional Information

The official instruction, CR 8775, issued to your MAC regarding this change, is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2977CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Competitive Bidding Program (CBP): Correction to VIPS Medicare System (VMS) Processing of Wheelchair Accessory Claims for Round 2 (MM8864) (MOB)

MLN Matters® Number: MM8864
Related CR Release Date: August 15, 2014
Related CR Transmittal #: R1420OTN

Related Change Request (CR) #: CR 8864
Effective Date: January 1, 2015
Implementation Date: January 5, 2015 - For claims processed on and after January 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) for standard power wheelchair and manual wheelchair accessories furnished to Medicare beneficiaries who reside in competitively bid areas (CBAs) as well as some items for beneficiaries residing outside a CBA.

Provider Action Needed

Change Request (CR) 8864 is a clarification of CR8181 that gave providers guidance regarding the Centers for Medicare & Medicaid Services (CMS) claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in a CBA.

For the purpose of CR8864, "Round 1" refers to the original Round 1 and not the Round 1 Rebid. "Round 2" refers to Round 2 and any subsequent Rounds (such as the Round 2 Recompete).

CR8864 implements corrections within Medicare systems to address the following:

1. Payments for wheelchair accessories furnished for use with Complex Group 2 and Group 3 Power Wheelchairs (identified by HCPCS K0835 - K0843 and K0848 - K0864) by contract suppliers for beneficiaries residing in a CBA;

2. Payments for competitively bid wheelchair accessories furnished for use with wheelchair base units that were not bid in Round 1 or Round 2 by contract and non-contract suppliers for beneficiaries residing in a CBA;

3. Payments for competitively bid wheelchair accessories that were not bid in Round 1 and that were furnished for use with any wheelchair base unit to beneficiaries residing outside a CBA; and

4. Payments for competitively bid wheelchair accessories that were not bid in Round 1 and that were furnished for use with wheelchair base units that were not competitively bid in Round 2 to beneficiaries residing in a CBA.

Additionally, effective for claims processed on or after January 1, 2015, MACs will allow payment for wheelchair accessories that are furnished for use with a non-competitively bid base unit, even if the accessories are received after the end date of the certificate of medical necessity (CMN). These accessories can be supplied by any Medicare-enrolled supplier provided they append modifier "KY".

Make sure your billing staffs are aware of these changes.

Background

Section 302 of *the Medicare Modernization Act* of 2003 (MMA) established requirements for a new Competitive Bidding Program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas.

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

Policy Scenarios

Effective for claims processed on or after January 1, 2015, MACs will apply the policy indicated to payments made for wheelchair accessories during Round 2 in each of the following scenarios:

Scenario 1

In this scenario, MACs will pay the fee schedule amount (-9.5 percent) for the wheelchair accessory used with the non-bid wheelchair base rather than paying the single payment amount (SPA).

- Wheelchair accessory is competitively bid in Round 1 **and** Round 2;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2);
- Billed with modifier "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

Scenario 2

In this scenario, MACs will pay the fee schedule amount (5%) for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 1 **and** Round 2;
- Billed for use with a non-competitively bid base unit that was not bid in Round 1 or Round 2 (HCPCS codes K0005, K0009, K0898, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1239);
- Billed with modifiers "KE" **and** "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

Scenario 3

In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with any wheelchair base unit (whether competitively bid or not);
- Billed without modifier "KE" or "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides outside a CBA.

Scenario 4

In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2) **OR** for use with a non-competitively bid base unit that was not bid in Round 1 or Round 2 (HCPCS codes K0005, K0009, K0898, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1239);
- Billed with modifier "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

> **Note:** *For wheelchair accessories, modifier "KY" is used in these instructions to identify Round 2 competitively bid wheelchair accessories that should be paid at fee schedule when billed for use with a base unit that was not bid in Round 2, even when provided to a beneficiary that resides in a CBA and without regard to the contract status of the supplier.*

Additional Information

The official instruction, CR 8864 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1420OTN.pdf on the CMS website.

To review MLN Matters® Article 8181, you may visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8181.pdf on the CMS website.

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

DMEPOS Competitive Bidding Round 2 Recompete and National Mail-Order Recompete Announced (GEN)

On July 15, the Centers for Medicare & Medicaid Services (CMS) announced plans to recompete the supplier contracts awarded in Round 2 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 2 contract period for all product categories expires on June 30, 2016.

Round 2 Recompete

The Round 2 Recompete product categories are:

- Enteral Nutrients, Equipment and Supplies
- General Home Equipment and Related Supplies and Accessories (includes hospital beds and related accessories, group 1 and 2 support surfaces, commode chairs, patient lifts, and seat lifts)
- Nebulizers and Related Supplies
- Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories
- Respiratory Equipment and Related Supplies and Accessories (includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories)
- Standard Mobility Equipment and Related Accessories (includes walkers, standard power and manual wheelchairs, scooters, and related accessories)
- Transcutaneous Electrical Nerve Stimulation (TENS) Devices and Supplies

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website.

CMS is conducting the Round 2 Recompete in the same geographic areas that were included in Round 2. However, as a result of the Office of Management and Budget's updates to the original 91 Round 2 metropolitan statistical areas (MSAs), there are now 90 MSAs for the Round 2 recompete. The Round 2 Recompete competitive bidding areas (CBAs) have nearly the same ZIP codes as the Round 2 CBAs. However, certain ZIP codes have changed since Round 2 and CMS has updated the CBAs to reflect the changes. Also, CBAs that were located in multi-state MSAs have been defined so that no CBA is included in more than one state. A list of the ZIP codes included in each CBA is also available on the CBIC website.

National Mail-Order Recompete

CMS will also be conducting the national mail-order recompete for diabetic testing supplies at the same time as the Round 2 Recompete. The national mail-order recompete will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Important Dates

To ensure that suppliers have ample time to prepare for the competition, CMS has announced the following next steps for the program:

July 15, 2014

- CMS begins pre-bidding supplier awareness program

Fall, 2014

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter, 2015

- Bidding begins

If you are a supplier interested in bidding, prepare now - don't wait.

Review and Update Enrollment

Suppliers must maintain accurate information on its CMS-855S with the National Supplier Clearinghouse (NSC) and in the Provider Enrollment, Chain and Ownership System (PECOS).

- Contact information (name, Social Security number, and date of birth) for authorized official(s) and correspondence address.
- Products and services furnished by the enrolled location(s).
- Each state in which the enrolled location(s) provides items and services.
- If you have only one authorized official listed on your enrollment file, consider adding one or more eligible authorized officials to help with registration and bidding. It is important to note that if your file is not current at the time of registration, you may experience delays and/or be unable to register and bid.

Get Licensed

Contracts are only awarded to suppliers who meet all state licensure requirements by the close of the bid window. Therefore, you must have all required state licenses for the physical location(s) that provides the items in the product category(s). Each physical location on your bid must be licensed for the product category by the state in which it provides items and services. Suppliers bidding in the national mail-order recompete must possess all applicable licenses in order to be awarded a contract in this competition. Copies of these licenses should be on file with the NSC and in PECOS.

A licensure guide for each state, the District of Columbia, and the territories are located on the National Suppler Clearinghouse website. These guides provide general licensure requirements for each product category included in the Competitive Bidding Program and contact information for each state's licensing board or agency. These are only guides. Licensing requirements change periodically, and it remains the responsibility of the bidding supplier to identify and obtain all required licenses. For more information about licensure requirements, please consult the appropriate license issuing agency listed on the guides or call the NSC at 866-238-9652.

Get Accredited

In order to submit a bid, each supplier location must be accredited by a CMS approved accrediting organization for the items they provide in a product category. Suppliers who are interested in bidding for a product category and who do not have its location(s) currently accredited for that product category, must take action NOW to get accredited for that product category. Accreditation organizations report any accreditation updates to the NSC, so it is important that you get accredited early so your information will be up-to-date. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation are available on the Medicare Provider-Supplier Enrollment website.

New and Improved CMS.gov Website

In conjunction with the Round 2 Recompete and the national mail-order recompete, CMS has updated the DMEPOS Competitive Bidding website. The website has been streamlined, so users will be able to easily navigate the webpages by specific rounds and topics. Please make sure you bookmark http://www.cms.gov/DMEPOSCompetitiveBid for the latest information on the DMEPOS Competitive Bidding Program.

Fingerprint-based Background Check Begins August 6, 2014 (SE1427) (GEN)

MLN Matters® Number: SE1427
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for providers and suppliers subject to fingerprint-based background check, submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

STOP - Impact to You

Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

CAUTION - What You Need to Know

The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Providers or suppliers will receive notification of the fingerprint requirements from their MAC. Initially, not all providers and suppliers in the "high" screening category will be a part of the first phase of the fingerprint-based background check requirement. See the Background section below for more details.

GO - What You Need to Do

If you receive notification of the fingerprint requirements, you will have 30 days from the date of the letter to be fingerprinted. Make sure that your staffs are aware of these requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) awarded the Fingerprint-based Background Check contract to Accurate Biometrics located in Chicago, Illinois on July 8, 2014. Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the "high" screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare.

Generally the relevant individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed. The relevant individuals will have 30 days from the date of the letter to be fingerprinted.

If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The relevant individuals should contact Accurate Biometrics prior to being fingerprinted to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics may be contacted by phone (866-361-9944) or by accessing their website at http://www.cmsfingerprinting.com if you have any questions.

If an initial enrollment application is received by the MAC and the provider or supplier is required to obtain a fingerprint-based background check, the MAC will not begin processing the application until the fingerprint-based background check has been completed and the results are received. The effective date of enrollment will be determined by the date the fingerprint results are received.

Additional Information

For more information on the Fingerprint-based Background Check requirement, view MLN Matters® article SE1417, "*Implementation of Fingerprint-Based Background Checks*", available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf on the CMS website. You may also want to review MM7350 titled, "*Implementation of Provider Enrollment Provisions in CMS-6028-FC*" available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7350.pdf on the CMS website.

Healthcare Provider Taxonomy Codes (HPTC) Update, October 2014 (MM8866) (GEN)

MLN Matters® Number: MM8866
Related CR Release Date: August 22, 2014
Related CR Transmittal #: R3037CP

Related Change Request (CR) #: CR 8866
Effective Date: October 1, 2014
Implementation Date: January 5, 2015 - If capable, MACs can implement this effective October 1, 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 (HH&H) MACs and Durable Medical Equipment (DME) MACs for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8866 implements the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Codes (HPTC) code set that is effective on October 1, 2014, and instructs MACs 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) X12 837 institutional and professional Technical Report Type 3 (TR3s) require the NUCC HPTC set be used to identify provider specialty information on a health care claim. The standards do not mandate the reporting of provider specialty information via a HPTC on every claim, nor for every provider to be identified by specialty.

The standard implementation guides state 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. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.*

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. 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 HPTC set is maintained by the NUCC for standardized classification of health care providers. 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) website at http://www.wpc-edi.com/codes on the internet.

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, CR8866 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3037CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Intravenous Immune Globulin (IVIG) Demonstration - Implementation (SE1424) (SPE)

MLN Matters® Number: SE1424 Revised
Related CR Release Date: N/A
Related CR Transmittal N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation: N/A

Note: *This article was revised on August 28, 2014, to amend some of the billing instructions, particularly with regard to date of service on the Q2052 claim line. Also, some questions and answers related to supplier eligibility are added to the article.*

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services to Medicare beneficiaries.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider Action Needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of October 1, 2014, and will continue for three years, as long as funding remains available.

Background

Depending on the circumstances, traditional fee-for-service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound, and is otherwise receiving services under a Medicare Home Health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

IVIG Demonstration

The "*Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012*" authorized the demonstration under Part B of Title XVIII of the *Social Security Act*. The demonstration is limited to no more than 4,000 beneficiaries, and the $45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. Also, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary Eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration (on the eligibility file provided by NHIC, Corp., the implementation support contractor);

2. The beneficiary must be eligible to have the IVIG drug paid for at home (has a diagnosis of PIDD) under the traditional Medicare benefit;

3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);

4. The beneficiary must not be covered on the date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.)

5. The place of service must be the beneficiary's home or a setting that is "home like".

Billing Details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration:

> Q2052 - (Long Description) - Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.
>
> Q2052 - (Short Description) - IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim for the IVIG drug itself.

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be $300 each time the IVIG is administered. While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes (as updated by CR 8724) represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

> **Note:** *If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same place of service code on the claim line as the IVIG (J code) for which it is applicable. In cases where the drug is mailed or delivered to the patient prior to administration, the date of service for the administration of the drug (the "Q2052" claim line) may be no more than 30 calendar days after the date of service on the drug claim line.*

If multiple administrations of IVIG are submitted on a single claim, each date of service for the administration of the drug (Q2052) must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a Group Code of CO (Contractual Obligation), a Remittance Advice Remarks Code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a Claim Adjustment Remarks Code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (Non-covered charge(s)), and a Group Code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare Secondary Payer process as well.

Questions and Answers Relating to Supplier Eligibility

Question: Is the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Supplier required to be certified to bill the A/B MACs in order to provide the nursing component of the Q2052 - Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

Answer: No. The DMEPOS supplier must currently be able to bill the DME MACs (enrolled and current with the National Supplier Clearinghouse) and meet all regulatory and statutory requirements. If a state requires licensure to furnish certain items or services, a DMEPOS supplier: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by State law. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.

Question: Can the supplier/pharmacy contract or subcontract nursing services for the administration of the IVIG to bill the Q2052 - Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

Answer: Yes. If a state requires licensure to furnish certain items or services, a supplier/pharmacy: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by State law.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other federal procurement or non-procurement programs.

How Beneficiaries can apply for the IVIG Demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. **Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.**

CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claims processing systems.

CMS will conduct an initial enrollment period from 8/08/2014 - 9/12/2014. Completed applications must be received by NHIC, Corp. no later than 5:00 pm Eastern Time on 9/12/2014 to be considered. Incomplete applications will be returned to the beneficiary and will not be reviewed. Beneficiaries will be notified by 9/30/2014 whether or not they have been accepted. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the 9/12/2014 deadline on a rolling basis until enrollment and/or funding limits are reached.

The enrollment application and the application completion guide are available at: http://www.medicarenhic.com or through the IVIG Demo Hot Line at: (844)-625-6284.

Completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

Applications may be mailed to:

NHIC, Corp.
IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp
IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to:

781-741-3533

Additional Information

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

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

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

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

Note: *This article was revised on June 9, 2014, to emphasize that coding "CT" in front of the clinical trial number applies ONLY to paper claims. The "CT" is not to be coded on electronic claims. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

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

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

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

Background

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

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

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

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

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

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

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (**do not use CT on the electronic claim, e.g., 12345678**) when a clinical trial claim includes:

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

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

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

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

Additional Information

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

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

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

Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs) (SE1231) (MOB)

MLN Matters® Number: SE1231 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 August 7, 2014, to add information regarding the addition of 12 states (Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington) to the demonstration.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for Medicare Fee-For-Service (FFS) suppliers who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Power Mobility Devices (PMDs) in the demonstration states (Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What You Need to Know

PMDs includes power wheelchairs and Power-Operated Vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of Durable Medical Equipment (DME) for Medicare coverage purposes.

Power Operated Vehicles (POVs or scooters): Under the Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, or manually operated wheelchair.

In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (Motorized) Wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare Fee-For-Service Program. CMS is conducting a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines for orders written on or after September 1, 2012. The demonstration was initially implemented in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. **Due to the demonstration's early success, the demonstration will be expanded to 12 additional states: Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington.** These 19 States accounted for 71 percent of the total Medicare PMD expenditures in 2011. The expanded demonstration will be effective for orders written on or after October 1, 2014. This demonstration targets a claim type known to be susceptible to fraud and that has had high rates of improper payments.

The demonstration implements a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration States. The prior authorization request can be completed by the ordering physician/ practitioner or the DME supplier. The physician/practitioner or supplier who submits the request is referred to as the "submitter." The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration States:

- Group 1 Power Operated Vehicles (K0800-K0802 and K0812);
- All standard power wheelchairs (K0813 through K0829);
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843);
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855);
- Pediatric power wheelchairs (K0890-K0891); and
- Miscellaneous power wheelchairs (K0898).

Note: *Group 3 complex rehabilitative power wheelchairs with power options (K0856 through 0864) are excluded.*

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the 7 element order, the detailed product description, and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/ practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 2 business days. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non- affirmative prior authorization decision will not be paid by Medicare.

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, the DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/ practitioner, and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision. However, the claim will be subject to prepayment review. CMS currently assesses a payment reduction for orders written on or after December 1, 2012, in the initial demonstration states. CMS will begin to assess a payment reduction for noncompliance with the prior authorization process for any orders written on or after January 1, 2015, in the 12 additional states. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS Competitive Bidding Program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at http://go.cms.gov/PADemo on the CMS website.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key Points

CMS initially conducted this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on the beneficiary's address as reported to the Social Security Administration and recorded in Medicare's Common Working File (CWF). This demonstration will expand to Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington for orders written on or after October 1, 2014. This demonstration involves all four DME MACs.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

Additional Information

The Prior Authorization of Power Mobility Device Section of the CMS web page is at http://go.cms.gov/PADemo on the CMS website.

MLN Matters® Special Edition Article SE1112, "*Power Mobility Device Face-to-Face Examination Checklist*," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "*Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements*," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf on the CMS website.

Please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html for the latest MLN educational products designed to help Medicare FFS Providers understand - and avoid - common billing errors and other improper activities.

You may want to review MLN Matters® article MM8056, which is available at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8056.pdf on the CMS website. The article clarifies that only one G9156 code (for preauthorization incentive payment) may be billed, per beneficiary, per PMD even if the physician or treating practitioner must resubmit the prior authorization request.

Medicare Remit Easy Print (MREP) Enhancement (MM8856) (GEN)

MLN Matters® Number: MM8856
Related CR Release Date: August 1, 2014
Related CR Transmittal #: R1413OTN

Related Change Request (CR) #: CR 8856
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8856. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare and Medicaid Services (CMS) to help providers to transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR8856 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

Background

CMS offers free software - Medicare Remit Easy Print (MREP) - to view and print HIPAA compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers and suppliers to help them transition to ERA. The MACs will notify MREP users of the MREP enhancements once implementation is complete. A key change in this latest version of the software is an enhancement to correct paging issues when a long claim runs to another page and that subsequent page was missing headers.

Additional Information

The official instruction, CR8856 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1413OTN.pdf on the CMS website.

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

Medicare Signature Requirements - Educational Resources for Health Care Professionals (SE1419) (GEN)

MLN Matters® Number: SE1419
Related CR Release Date: N/A
Related CR Transmittal #:N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order or provide Medicare-covered services to Medicare beneficiaries.

Provider Action Needed

STOP - Impact to You

Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable. If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted.

CAUTION - What You Need to Know

Medicare services provided/ordered must be authenticated by the author using an acceptable signature.

GO - What You Need to Do

Use this article as a reference to available educational resources related to signature requirements for Medicare-covered services.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand signature requirements for Medicare-covered services.

1. **Medicare Quarterly Compliance Newsletter**
   - The Medicare Quarterly Provider Compliance Newsletter (January 2014) highlights Comprehensive Error Rate Testing (CERT) circumstances as a result of insufficient documentation.

2. Articles
   - MM5971: "**CR 5550 Clarification – Signature Requirements**" clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It states that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness hospice.
   - MM6100: "**Physician Signature Requirements for Diagnostic Tests**" notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

- MM6261: "**Signature and Date Stamps for DME Supplies – Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)**" alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. It states signature and date stamps are not acceptable for use on CMNs and DIFs. Medicare contractors will only accept hand written, facsimiles of original written and electronic signatures and dates on medical documentation for medical review purposes on CMNs and DIFs.

- MM6698: "**Signature Guidelines for Medical Review Purposes**" outlines the new rules for signatures and adds language of E-Prescribing beginning on or after April 16, 2010. The article covers signature logs and attestation statements. A helpful table summarizing examples where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit a signature log or attestation statement.

- MM7337: "**Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation**" states, if the narrative is part of the certification or recertification form it must be located immediately above the physician's signature. If the narrative is an addendum to the form, (in addition to the physician's signature on the certification or recertification form) the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician's signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.

- MM8219: "**Use of Rubber Stamp for Signature**" highlights the exception for the use of rubber stamps in accordance with the *Rehabilitation Act* of 1973 in the case of the author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. Under this circumstance, by affixing the rubber stamp, the provider is certifying that they have reviewed the document.

- SE1219: "**A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter**" includes a short section on signature requirements for face-to-face documentation.

- SE1308: "**Physicians Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)**" addresses the authority of nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) to sign orders, certification, and recertification in SNFs and NFs.

- SE1405: "**Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-tot-Face Encounter**" notes that the homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by a physician, titled "Home Health Face-to-Face Encounter", and dated.

3. **Fact Sheets:**
   - ICN 905063: "**Power Mobility Devices: Complying with Documentation and Coverage Requirements**" discusses the need for a signature on both the prescription and the detailed product description from the supplier by the treating physician.

   - ICN 905364: "**Complying With Medicare Signature Requirements**" provides answers to questions, as well as a list of resources, about Medicare signature requirements.

   - ICN 905064: "**Continuous and Bi-Level Positive Airway Pressure (CPAP/BPAP) Devices: Complying with Documentation and Coverage Requirements**" states the order/prescription must be signed by the treating physician who ordered the device. The description may be written by someone else, but the treating physician must sign the order.

Additional Information

To review detailed Medicare signature requirements read Chapter 3 of The "*Medicare Program Integrity Manual*" located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf on the CMS website.

For more information about provider compliance, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website.

The MLN Educational Web Guides' "*MLN Guided Pathways to Medicare Resources*" help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about protecting the Medicare Trust Fund, refer to the "*Protecting the Medicare Trust Fund*" section in the "*MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers*" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "*Guided Pathways*" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.

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

MLN Matters® Number: MM8812
Related CR Release Date: August 22, 2014
Related CR Transmittal #: R3048CP, R238FM
Related Change Request (CR) #: CR 8812
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

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

What You Need to Know

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

Background

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

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

Additional Information

The official instruction, CR 8812 issued to your MAC regarding this change is available in 2 transmittals at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3048CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R238FM.pdf on the CMS website.

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

October 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8836) (DRU)

MLN Matters® Number: MM8836
Related CR Release Date: July 18, 2014
Related CR Transmittal #: R2990CP

Related Change Request (CR) #: CR 8836
Effective Date: October 1, 2014
Implementation Date: October 6, 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 and Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8836 instructs MACs to download and implement the October 2014 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2014, April 2014, January 2014, and October 2013, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 6, 2014, with dates of service October 1, 2014, through December 31, 2014. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, section 50, of the "*Medicare Claims Processing Manual*" which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website. The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013

Note: *CMS requires physicians and other providers to bill using the appropriate HCPCS or Current Procedural Terminology (CPT) code and to accurately report the units of service. Physicians and other providers should ensure the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy, as noted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html on the CMS website.*

Additional Information

The official instruction, CR 8836 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2990CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

October Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8865) (GEN)

MLN Matters® Number: MM8865
Related CR Release Date: August 1, 2014
Related CR Transmittal #: R3011CP

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

Key Points of CR8865

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

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

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

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

Off-the-Shelf (OTS) Orthotics

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

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

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "*Medicare Claims Processing Manual*,"

Chapter 23, Section 60.3.1. at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

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

Specific Coding and Pricing Issues

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

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

Additional Information

The official instruction, CR8865 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3011CP.pdf on the CMS website.

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

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

Revised Modification to the Medically Unlikely Edit (MUE) Program (MM8853) (GEN)

MLN Matters® Number: MM8853
Related CR Release Date: August 15, 2014
Related CR Transmittal #: R1421OTN

Related Change Request (CR) #: CR 8853
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8853 informs MACs about additional modifications being updated in the Medically Unlikely Edit (MUE) Program. The updates include clarifications, general processing instructions, and detailed explanations of MUE requirements and specifications. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. At that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is currently assigning a MAI to each HCPCS code. CR8853 contains current and updated background information for these modifications, including general processing instructions.

MUEs for HCPCS codes with a MAI of "1"

MUEs for HCPCS codes with a MAI of "1" will continue to be adjudicated as a claim line edit.

MUEs for HCPCS codes with a MAI of "2"

MUEs for HCPCS codes with a MAI of "2" are absolute date of service edit. These are "per day edits based on policy". HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and the MACs.

Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the *Health Insurance Portability & Accountability Act* of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and National Correct Coding Initiatives (NCCI) manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for Current Procedural Terminology (CPT) 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

> **Note:** *Although the Qualified Independent Contractors (QICs) and the Administrative Law Judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and are being made aware that CMS considers all edits with an MAI of 2 to be firm limits based on subregulatory guidance, while some MUE edits with an MAI "2" may be based directly on regulation or statute.*

MUEs for HCPCS codes with a MAI of "3"

MUEs for HCPCS codes with a MAI of "3" are date of service edits. These are "per day edits based on clinical benchmarks". If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of "3" during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General Processing Instructions

- Since ambulatory surgical center (ASC) providers (specialty code 49) cannot report modifier 50, the MUE value used for editing will be doubled for HCPCS codes with an MAI of "2" or "3" if the bilateral surgery indicator for the HCPCS code is "1".

- CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that you bring to their attention.

- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to your MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of "1" or "3" may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.

- Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of "3", MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of "1." CMS interprets the notice delivery requirements under Section1879 of the *Social Security Act* (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not

based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the *Social Security Act*. Thus, ABN issuance based on an MUE is NOT appropriate.

- CMS reminds providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the "*Medicare Claims Processing Manual*" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf on the CMS website. Clerical errors (which includes minor errors and omissions) may be treated as reopenings.

- CMS encourages providers to change and resubmit their own claims where possible and to change their coding practices, but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR.

- CMS also reminds providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.

- On your Remittance Advice, MACs will continue to use Group Code CO (contractual obligation), and remark codes N362 and MA01 for claims that fail the MUE edits, when the UOS on the claim exceed the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.

Additional Information

The official instruction, CR 8853 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.pdf on the CMS website.

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

Two New "K" Codes for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS) (MM8839) (O&P)

MLN Matters® Number: MM8839 Revised
Related CR Release Date: August 26, 2014
Related CR Transmittal #: R3052CP

Related Change Request (CR) #: CR 8839
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Note: *This article was revised on August 28, 2014, to reflect the revised CR8839 issued on August 26, 2014. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8839 announces that, effective October 1, 2014, two new "K" codes (K0901 and K0902) will be established for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS). The addition of these codes will allow the DME MACs to correctly adjudicate claims. Make sure your billing staffs are aware of these changes.

Background

Definitions

- The orthotics currently paid under Section 1834(h) (Payment for Prosthetic Devices and Orthotics and Prosthetics) of the *Social Security Act* (the Act), and that are described in its Section 1861(s)(9) (Part E - Miscellaneous Provisions, Definitions of Services, Institutions, etc.) are leg, arm, back, and neck braces. (You can find these sections of the Act at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm, and http://www.ssa.gov/OP_Home/ssact/title18/1861.htm, respectively).

- The "*Medicare Benefit Policy Manual*," Chapter 15 (Covered Medical and Other Health Services), Section 130 (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) provides the longstanding Medicare definition of "braces" as "rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body." (You can find this manual section at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website).

- Further, Section 1847(a)(2) of the Act defines OTS orthotics as those for which payment would otherwise be made under Section 1834(h), above; which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. You can find this section of the act at http://www.ssa.gov/OP_Home/ssact/title18/1847.htm.

- Lastly, the Center for Medicare & Medicaid Services (CMS) regulations at 42 CFR 414.402, which you can find at http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/html/CFR-2007-title42-vol3-sec414-402.htm, define the term "minimal self-adjustment" as "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 (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training."

New OTS Orthotics Healthcare Common Procedure Coding System (HCPCS) Codes

In February 2012, CMS issued guidance that initially identified specific HCPCS codes that were considered OTS orthoses. The list of HCPCS codes that were finalized as part of this review as OTS orthotics, effective January 1, 2014, are available for download at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

CR8839announces that in order to identify prefabricated single and double upright knee orthoses that are furnished in a variety of standard sizes and do not require the skills of an expert to measure and fit to the individual; the following OTS codes will be added to the HCPCS code set, effective October 1, 2014:

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

Additional Information

The official instruction, CR8839 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3052CP.pdf on the CMS website.

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

Fee Schedule Updates (GEN)

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

The following Fee Schedules have been added:

- There are no updates to the 3rd Quarter 2014 Jurisdiction A DME MAC Fee Schedule
- 3rd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2014 Oral Anticancer Drug Fees

The following Fee Schedules have been revised:

- 2nd Quarter 2014 Oral Anticancer Drug Fees
- 2nd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 3rd 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.

First Level Appeal requests now accepted via esMD (GEN)

NHIC DME MAC Jurisdiction A is pleased to announce that we now accept First Level Appeal requests via esMD in PDF format. This new functionality was implemented on July 14th as part of the CMS esMD release 3.0. In addition to this new functionality, NHIC JA will continue to accept Medical Documentation Responses, PMD Prior Authorization requests, and will continue to send PMD Prior Authorization Review Results Messages via esMD.

Need Additional Information?

For additional information regarding esMD, providers and suppliers should refer to the following resources located on the CMS Web site: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html

CMS News Flash (GEN)

New Products from the Medicare Learning Network® (MLN)

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

Protecting Access to Medicare Act of 2014
Podcast, ICN 909050, Downloadable only.
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/2014-07-31-Podcast-909050.html

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

Medicare Billing: 837I and Form CMS-1450
Web-based Training (WBT)
https://cms.meridianksi.com/kc/main/pop_up_frm.asp?loc=/kc/ilc/course_info_enroll_info.asp%3Fpreview%3DFalse%26crs_ident%3DC00206&strFunction=width%3D200%2Cheight%3D100&strTable=undefined&strContentID=undefined

Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]
Educational Tool, ICN 909012, downloadable
http://www2b.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909012.html

Revised Products from the Medicare Learning Network® (MLN)

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

Suite of Products & Resources for Billers and Coders
Educational Tool, ICN 904183, Downloadable only
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Billers_and_Coders_Suite_of_Products_Listings.pdf

Medicare Overpayment Collection Process
Fact Sheet, ICN 006379, downloadable
http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OverpaymentBrochure508-09.pdf

Medicare Enrollment Guidelines for Ordering/Referring Providers
Fact Sheet (ICN 906223), downloadable
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf

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

The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
Suppliers Fact Sheet ICN 904283, Downloadable only
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf

The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners
Fact Sheet, ICN 903764, Downloadable only
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf

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!

Staying Connected

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

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.

2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available

The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs (http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html) web page and 2015 ICD-10-PCS and GEMs (http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Connects™ Provider eNews (GEN)

MLN Connects™ Provider eNews for Thursday, June 12, 2014

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

MLN Connects™ National Provider Calls

- PQRS: 2014 Qualified Clinical Data Registry - Last Chance to Register
- New Medicare PPS for FQHCs: Operational Requirements - Register Now
- New MLN Connects™ National Provider Call Transcripts and Audio Recordings

MLN Connects™ Videos

- Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014
- PQRS Program: What Medicare Eligible Professionals Need to Know in 2014
- Medicare and Medicaid EHR Incentive Programs: What Providers Need to Know in 2014

CMS Events

- Medicare Learning Network® Webinar: How Effective is Your Compliance Program?
- PERM Cycle 3 Provider Education Webinar/Conference Call Sessions
- ICD-10 Documentation and Coding Concepts Webcast: Cardiology
- ICD-10 Documentation and Coding Concepts Webcast: Pediatrics

Announcements

- Looking for LCDs Converted to ICD-10?
- Open Payments (the *Sunshine Act*) CMS Registration Underway: Instructions Available
- Open Payments (the *Sunshine Act*) User Guide and Help Desk
- New and Updated HIS Content Available
- CMS to Release a Comparative Billing Report on Electrodiagnostic Testing in June
- CMS Announces Teaching Hospital Closures and Round 7 of Section 5506 of the *Affordable Care Act*
- EHR Incentive Programs: Provide Feedback on Draft Combined 2015 QRDA Implementation Guide by June 27
- EHR Incentive Programs: NPRM Comment Period Now Open: Submit by July 21
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- PQRS Resources Posted to CMS eHealth University

Claims, Pricers, and Codes

- July 2014 Average Sales Price Files Now Available

MLN Educational Products

- "The Basics of Internet-based PECOS for DMEPOS Suppliers" Fact Sheet - Revised
- MLN Products Available In Electronic Publication Format

MLN Connects™ Provider eNews for Thursday, June 19, 2014

http://go.cms.gov/UMqZky

MLN Connects™ National Provider Calls

- New Medicare PPS for FQHCs: Operational Requirements - Last Chance to Register
- ESRD Quality Incentive Program: Reviewing Your Facility's PY 2015 Performance Data - Registration Now Open
- ESRD Quality Incentive Program: Notice of Proposed Rulemaking for PY 2017 and 2018 - Registration Now Open
- New MLN Connects™ National Provider Call Video Slideshow, Transcript, and Audio Recording

CMS Events

- ICD-10 Documentation and Coding Concepts Webcast: Obstetrics and Gynecology

Announcements

- Has Your Hospice Registered for the User IDs Required to Submit HIS Data?
- Open Payments (The *Sunshine Act*): Reminder to Complete Phase 1 Registration: Enterprise Portal
- CMS is Accepting Suggestions for PQRS Measures
- Medicare EHR Incentive Program: Hardship Exception Application Deadline July 1
- EHR Incentive Programs: Updated Eligible Professional QRDA I and III Packages

Claims, Pricers, and Codes

- Phase 2 Ordering and Referring Denial Edits for Physicians Certifying HHA Services

MLN Educational Products

- "How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database" MLN Matters® Article - Released
- "Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Guide" MLN Matters® Article - Revised

MLN Connects™ Provider eNews for Thursday, June 26, 2014

http://go.usa.gov/9m3B

MLN Connects™ National Provider Calls

- Dialysis Facility Compare: Rollout of Five Star Rating - Registration Now Open

- ESRD Quality Incentive Program: Reviewing Your Facility's PY 2015 Performance Data - Register Now
- ESRD Quality Incentive Program: Notice of Proposed Rulemaking for PY 2017 and 2018 - Register Now
- Proposals for Quality Reporting Programs under the 2015 Medicare PFS - Registration Opening Soon
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- ICD-10 Documentation and Coding Concepts Webcast: Family Practice/Internal Medicine

Announcements

- National HIV Testing Day - June 27
- Looking for LCDs Converted to ICD-10?
- Hospices: Begin Collecting HIS Data July 1 to Avoid Reduction in FY 2016 Annual Payment Update
- PEPPERs Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Eligible Professionals: EHR Hardship Exception Applications Due July 1
- Eligible Professionals: Review the Lists of Qualified Registries and QCDRs for 2014 PQRS Participation
- New PQRS Frequently Asked Questions Available

Claims, Pricers, and Codes

- Learn More about the New Remittance Advice Codes for PQRS Claims-Based Reporting

MLN Educational Products

- "Drug Diversion: Do You Know Where the Drugs Are Going?" Web-Based Training Course - Released
- "Top Ten Frequently Asked Questions About Remittance Advice" Fact Sheet - Released
- "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Educational Tool - Revised
- "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Educational Tool - Revised
- "Rural Referral Center Program" Fact Sheet - Revised
- "Swing Bed Services" Fact Sheet - Revised
- "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" Educational Tool - Reminder
- "Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training" Web-Based Training Course - Reminder
- New MLN Educational Web Guides Fast Fact
- New MLN Provider Compliance Fast Fact

MLN Connects™ Provider eNews for Thursday, July 03, 2014

http://go.cms.gov/1mKmUD3

MLN Connects™ National Provider Calls

- Dialysis Facility Compare: Rollout of Five Star Rating - Register Now
- ESRD Quality Incentive Program: Reviewing Your Facility's PY 2015 Performance Data - Register Now
- Open Payments (the *Sunshine Act*): Registration, Review, and Dispute - Registration Opening Soon
- ESRD Quality Incentive Program: Notice of Proposed Rulemaking for PY 2017 and 2018 - Register Now
- 2015 Medicare PFS Proposals for PQRS, Value Modifier, EHR Incentive Program, and the Physician Compare Website-Registration Now Open
- New MLN Connects™ National Provider Call Video Slideshow, Transcript, and Audio Recording

CMS Events

- Webinar for Comparative Billing Report on Electrodiagnostic Testing
- PERM Cycle 3 Provider Education Webinar/Conference Call Sessions

Announcements

- CMS Proposes Payment Changes for Medicare Home Health Agencies for 2015

- CMS Fraud Prevention System Identified or Prevented $210 Million in Improper Medicare Payments in Second Year of Operations
- Physician and Teaching Hospitals: Complete Phase 1 Registration for Open Payments
- Download Next Generation Mobile Apps for Open Payments

Claims, Pricers, and Codes

- CMS Releases Modifications to HCPCS Code Set
- ICD-10 Basics: Unspecified Diagnosis Codes, CPT Codes, and Version 5010 Standards

MLN Educational Products

- Summer 2014 Version of Medicare Learning Network Products Catalog Now Available
- "Medically Unlikely Edits (MUE) and Bilateral Procedures" MLN Matters® Article - Released
- "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]" Educational Tool - Released
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet - Revised
- "Complying with Medicare Signature Requirements" Fact Sheet - Reminder
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet - Reminder
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for Thursday, July 10, 2014

http://go.usa.gov/Xn9x

MLN Connects™ National Provider Calls

- ESRD Quality Incentive Program: Reviewing Your Facility's PY 2015 Performance Data - Last Chance to Register
- Open Payments (the *Sunshine Act*): Registration, Review, and Dispute - Registration Now Open
- ESRD Quality Incentive Program: Notice of Proposed Rulemaking for PY 2017 and 2018 - Register Now
- 2015 Medicare PFS Proposals for PQRS, Value Modifier, EHR Incentive Program, and the Physician Compare Website - Register Now
- New MLN Connects™ National Provider Call Video Slideshow, Transcript, and Audio Recording

Announcements

- Proposed Policy and Payment Changes to the Medicare Physician Fee Schedule for CY 2015
- CMS Proposes Hospital Outpatient and ASCs Policy and Payment Changes for CY 2015
- Medicare Proposes Updates for the ESRD PPS, Quality Incentive Program, and DMEPOS
- Open Payments System Registration Begins Mid-July
- Open Payments Review and Dispute Process Begins in Mid-July
- Hospice Item Set Help and Available Resources
- Delay in Implementing NCD for Single Chamber and Dual Chamber Cardiac Pacemakers
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- EHR Incentive Programs: Interactive Tool to Help Providers Understand 2014 CEHRT NPRM
- EHR Incentive Programs: Changes in the Vital Signs Core Objective in 2014

Claims, Pricers, and Codes

- Barcoded Coversheets Required for CERT Documentation Submissions
- New Schedule for CERT Documentation Requests as of May, 2014
- CERT Datasets Posted
- Looking for CERT Information?
- Quarterly Provider Specific Files for the Prospective Payment System Now Available

MLN Educational Products

- "Medicare Signature Requirements - Educational Resources for Health Care Professionals" MLN Matters® Article - Released
- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets" Educational Tool - Released

- "The Medicare Overpayment Collection Process" Fact Sheet - Revised
- "Medicare Physician Fee Schedule" Fact Sheet - Revised
- "Medicare Ambulance Transports" Booklet - Revised
- MLN Product Available in Electronic Publication Format

MLN Connects™ Provider eNews for Thursday, July 17, 2014

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

MLN Connects™ National Provider Calls

- Open Payments (the *Sunshine Act*): Registration, Review, and Dispute - Last Chance to Register
- ESRD Quality Incentive Program: Notice of Proposed Rulemaking for PY 2017 and 2018 - Last Chance to Register
- 2015 Medicare PFS Proposals for PQRS, Value Modifier, EHR Incentive Program, and the Physician Compare Website-Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes: Improved Care Transitions -Registration Now Open

CMS Events

- PERM Cycle 3 Provider Education Webinar/Conference Call Session

Announcements

- DMEPOS Competitive Bidding Round 2 Recompete and National Mail-Order Recompete Announced
- World Hepatitis Day – July 28
- Health Care Innovation Awards to Provide Better Health Care and Lower Costs
- Open Payments System Registration Began July 14
- Open Payments Review and Dispute Process Began July 14 and Ends August 27
- EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2
- New PQRS FAQs Available
- FAQs on PQRS MAV Process Available

Claims, Pricers, and Codes

- Update to the CWF Qualifying Stay Edit C7123 for Inpatient SNF Claims
- Hold Any Adjustments to Method II CAH Claims that Include Services for a Surgical Assistant
- Correction to Inappropriately Returned Hospice Claims
- July 2014 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products

- "Medicare Billing: 837I and Form CMS-1450" Web-Based Training Course - Released
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet - Revised
- "Advance Payment Accountable Care Organization (ACO) Model" Fact Sheet - Revised
- "Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program" Fact Sheet - Revised
- "Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program" Fact Sheet - Revised
- "Accountable Care Organizations: What Providers Need to Know" Fact Sheet - Revised
- "Improving Quality of Care for Medicare Patients: Accountable Care Organizations" Fact Sheet - Revised
- "Medicare Shared Savings Program and Rural Providers" Fact Sheet - Revised
- "Diagnosis Coding: Using the ICD-9-CM" Web-Based Training Course - Reminder
- New Continuing Education Association Now Accepting MLN Web-Based Training Courses
- MLN Products Available In Electronic Publication Format
- MLN Products Now Available In Hardcopy Format

MLN Connects™ Provider eNews for Thursday, July 24, 2014

http://go.usa.gov/5UTw

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes: Improved Care Transitions - Register Now

Announcements

- CMS Launches Next Phase of New Quality Improvement Program
- Group Practices Should Access PY 2012 Supplemental QRURs from CMS
- Physician Compare eNewsletter
- Comment Period Has Begun for CY 2015 Physician Fee Schedule Proposed Rule
- Review Your 2014 PQRS Interim Claims Feedback Data
- EHR Incentive Programs: Learn More about Clinical Decision Support Interventions

Claims, Pricers, and Codes

- Correction to SNF Consolidated Billing Code Lists

MLN Educational Products

- "Internet-based PECOS Contact Information" Fact Sheet - Revised
- MLN Products Available in Electronic Format
- New MLN Educational Web Guides Fast Fact

MLN Connects™ Provider eNews for Thursday, July 31, 2014

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

MLN Connects™ National Provider Calls

- How to Interpret Your 2012 Supplemental Quality and Resource Use Report - Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes: Improved Care Transitions -Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

Announcements

- Get Ready for DMEPOS Competitive Bidding - Get Licensed
- Hospice Item Set Record Submission Begins
- Don't Forget to Complete Open Payments System Registration
- Complete Review and Dispute Process for Open Payments by August 27
- Open Payments: Review Available Education Resources
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- ICD-10 Resources Spotlight: Road to 10
- Review the Combined 2015 CMS QRDA Implementation Guide

Claims, Pricers, and Codes

- Mass Adjustment of OPPS Claims
- July OPPS Provider Specific Files Now Available

MLN Educational Products

- MLN Web-Based Training Courses With Continuing Education Credits
- New Continuing Education Association Now Accepting MLN Web-Based Training Courses
- MLN Products Available In Electronic Publication Format
- New MLN Provider Compliance Fast Fact

MLN Connects™ Provider eNews for Thursday, August 07, 2014

http://go.usa.gov/NmS9

MLN Connects™ National Provider Calls

- How to Interpret Your 2012 Supplemental Quality and Resource Use Report - Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes: Improved Care Transitions - Register Now
- Continuing Education for Participation in MLN Connects™ National Provider Calls
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Special Open Door Forum: Medicare's Expanded Prior Authorization for Power Mobility Devices Demonstration

Announcements

- FY 2015 Payment and Policy Changes for Medicare Skilled Nursing Facilities
- FY 2015 Payment and Policy Changes for Medicare Inpatient Psychiatric Facilities
- FY 2015 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities
- FY 2015 Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit
- Vaccines Are Not Just for Kids
- Are You Providing an Annual Wellness Visit to Your Medicare Patients?
- Bundled Payments for Care Improvement Initiative
- LTCH Quality Reporting Program FY 2016 Second Quarter Submission Deadline is August 15
- IRF Quality Reporting Program FY 2016 First Quarter Submission Deadline is August 15
- Extension of Temporary Moratoria on Enrollment of New Home Health Agencies, Home Health Agency Sub-units and Part B Ambulance Suppliers
- Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice
- CMS to Release a Comparative Billing Report on Immunohistochemistry and Special Stains in August
- EHR Incentive Program: Learn More about the Stage 2 Electronic Notes Menu Objective
- Tips to Streamline Your Open Payments System Registration
- Correction to July 31 Article: Get Ready for DMEPOS Competitive Bidding – Get Licensed

Claims, Pricers, and Codes

- 2015 ICD-9-CM and ICD-10-CM POA Exempt Lists Now Available
- Adjustment of Some Hospital Claims for Therapy Services

MLN Educational Products

- "*Protecting Access to Medicare Act of 2014*" Podcast - Released
- "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 - Revised
- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article - Revised
- "Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015" MLN Matters® Article - Revised
- MLN Product Available In Electronic Publication Format

MLN Connects™ Provider eNews for Thursday, August 14, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-08-14-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-14-eNews.pdf

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes: Improved Care Transitions - Last Chance to Register

Announcements

- PQRS Measure-Applicability Validation (MAV) Course Available Online
- Visit the eCQM Library Page to Review the Combined 2015 CMS QRDA Implementation Guide
- PV-PQRS Registration Open Until September 30

Claims, Pricers, and Codes

- FY 2014 Inpatient PPS Pricer Updated
- FY 2014 Inpatient PPS PC Pricer Updated

MLN Educational Products

- MLN Suites of Products & Resources for Selected Audiences: Educators and Students, Billers and Coders, Inpatient Hospitals, Compliance Officers
- "Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)" MLN Matters® Article - Revised
- "Intravenous Immune Globulin (IVIG) Demonstration - Implementation" MLN Matters® Article - Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article - Released
- "DMEPOS Quality Standards" Booklet - Revised
- "The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): Information for Pharmacies" Fact Sheet - Revised
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet - Revised
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet - Revised
- New Continuing Education Association Now Accepting MLN Web-Based Training Courses
- MLN Product Available In Electronic Publication Format

MLN Connects™ Provider eNews for Thursday, August 21, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-08-21-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-21-eNews.pdf

MLN Connects™ National Provider Calls

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs - Registration Now Open
- New MLN Connects™ Video Slideshow

CMS Events

- Road to 10 Webcast Series
- PQRS Measure-Applicability Validation Course Available Online

Announcements

- Open Payments System Reopens, Extends Physician Registration and Review Period
- FY 2015 Hospice Reporting Cycle Data Analysis Available
- EHR Incentive Program: 2014 CQM Electronic Reporting Guides
- Correction to August 7 Article: LTCH Quality Reporting Program FY 2016 Second Quarter Submission Deadline is August 15

Claims, Pricers, and Codes

- Update to the CWF Qualifying Stay Edit C7123 for Inpatient SNF and SB Claims
- FY 2014 HH PPS PC Pricer Updated

MLN Educational Products

- "Medicaid Compliance and Your Dental Practice" Fact Sheet - Released
- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets" Educational Tool - Released
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet - Revised
- MLN Products Available In Electronic Publication Format

MLN Connects™ Provider eNews for August 28, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-08-28-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-28-eNews.pdf

MLN Connects™ National Provider Calls

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs - Register Now
- Overview of the 2013 Quality and Resource Use Reports - Registration Opening Soon
- New MLN Connects™ National Provider Call Video Slideshow, Audio Recording, and Transcript

Announcements

- NIST EHR Randomizer Tool: Provider User Guide Available
- Review New FAQs for the EHR Incentive Programs

Claims, Pricers, and Codes

- Update to Preventive Services Paid Based on the RHC or FQHC All-inclusive Rate
- Adjustment of Some Home Health Claims
- FY 2014 HH PPS PC Pricer Updated

MLN Educational Products

- "International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers" MLN Matters® Article - Released
- "ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" Fact Sheet - Revised
- "ICD-10-CM/PCS Myths and Facts" Fact Sheet - Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet - Revised
- "General Equivalence Mappings Frequently Asked Questions" Booklet - Revised
- "New Physician Specialty Code for Interventional Cardiology" MLN Matters® Article - Released
- "Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: Automation of the Request for Reopening Claims Process" MLN Matters® Article - Released
- "Fingerprint-based Background Check Begins August 6, 2014" MLN Matters® Article - Released
- "Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility (SNF) Certifications and Recertifications" MLN Matters® Article - Released
- "MLN Suite of Products & Resources for Rural Health Providers" Educational Tool - Revised
- New MLN Educational Web Guides Fast Fact
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for September 4, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-09-04-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-09-04-eNews.pdf

MLN Connects™ National Provider Calls

- CMS Offers Settlement to Acute Care Hospitals and CAHs for Resolving Patient Status Denials - Register Now

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs - Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript
- Providers and Suppliers - Browse the MLN Connects™ Call Program Collection of Resources

Announcements

- Get Ready for DMEPOS Competitive Bidding - Get Accredited
- Healthy Aging® Month - Discuss Preventive Services with your Patients
- New CMS Rule Allows Flexibility in Certified EHR Technology for 2014
- Open Payments System Outages

MLN Educational Products

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports" Educational Tool - Released
- "Intravenous Immune Globulin (IVIG) Demonstration - Implementation" MLN Matters® Article - Revised
- "Medicare Enrollment and Claim Submission Guidelines" Booklet - Revised
- "Medicare Vision Services" Fact Sheet - Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet - Revised
- New MLN Provider Compliance Fast Fact
- MLN Products Available in Electronic Publication Format

Appeals of Overpayment Demands

When requesting an Appeal of an Overpayment Demand please submit a copy of the Demand Letter along with all pertinent information, including the adjustment CCN. This will allow NHIC to identify the overpayment and properly suspend the Accounts Receivable during the Appeals process.

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

---

ACA 6407 Requirements - Corrections and Amendments to the Face-to-Face Visit and Written Order Prior to Delivery (WOPD) - Joint DME MAC Publication (GEN)

Note: *This is a revision to an article previously published on August 07, 2014 entitled, "Written Order Prior to Delivery - Corrections to Document"*

The *Affordable Care Act* §6407 requires that the treating physician conduct a face-to-face examination and provide a written order prior to delivery (WOPD) for certain items of durable medical equipment (DME). When the supplier receives the documentation of the face-to-face visit and it does not describe a medical condition for which the DME is being prescribed or the WOPD is defective (i.e., missing a required element), the following instructions describe the options for remedy.

I. If errors in the face-to-face visit documentation or WOPD are found prior to delivery, the supplier has two options:

   A. The supplier may request that the treating physician amend the face-to-face visit notes or the WOPD, whichever is applicable, following the guidance in the *Program Integrity Manual* (Internet-Only Manual, Publ. 100-08, Chapter 3, Section 3.3.2.5); or,

   B. A new face-to-face examination may be conducted or a new WOPD may be created, whichever is applicable.

II. If errors in the WOPD are found or the face-to-face visit notes do not describe a medical condition for which the DME is being prescribed and this is discovered after delivery of the item, the supplier has two options:

   A. If the error is discovered prior to claim submission, the original supplier may recover the delivered item(s), obtain a compliant, complete WOPD or face-to-face visit notes that describes a medical condition for which the DME is being prescribed, whichever is applicable, and then re-deliver the item(s) to the beneficiary; or,

   B. If the error is discovered after submitting a claim, the original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements.

Because the face-to-face visit and WOPD are statutory requirements, if there is a defective WOPD or the face-to-face visit notes do not describe a medical condition for which the DME is being prescribed, the claim will be denied and a beneficiary liability determination applied. Suppliers are strongly encouraged to review their WOPD documentation and the face-to-face visit notes carefully prior to delivery to ensure that all the requirements for coverage are met.

Ankle-Foot Orthoses: Walking Boots - Coverage and Coding Issues – Revised (O&P)

Effective: August 1, 2014

HCPCS codes L4360, L4361, L4386 and L4387 describe an ankle-foot orthosis commonly referred to as a walking boot. Walking boots that are used to provide immobilization as treatment for an orthopedic condition or following orthopedic surgery are eligible for coverage under the Brace benefit. When walking boots are used primarily to relieve pressure, especially on the sole of the foot, or are used for patients with foot ulcers, they are noncovered - no benefit category. Medicare covers therapeutic shoes, as described in the Therapeutic Shoes for Persons with Diabetes local coverage determination (LCD), for the prevention and treatment of diabetic foot ulcers.

Suppliers must add a GY modifier to HCPCS code L4360, L4361, L4386 or L4387 if the walking boot is only being used for the treatment or prevention of a foot ulcer. The absence of a GY modifier indicates that the walking boot is being used as part of the treatment for an orthopedic condition or following orthopedic surgery. Claims for HCPCS code L4360, L4361, L4386 or L4387 with a GY modifier will be denied as noncovered.

Prefabricated walking boots must be billed with HCPCS codes L4360, L4361, L4386 or L4387. Add-on codes must not be billed in addition to these HCPCS codes. Custom fabricated walking boots must be billed with HCPCS code L2999 and must be accompanied by information identifying the manufacturer and model name (if applicable), the indication(s) for use of the boot, and an explanation of why a prefabricated walking boot is not sufficient. Walking boots must not be billed with other AFO HCPCS codes, including but not limited to HCPCS codes L2106-L2116, or with HCPCS codes for therapeutic shoes.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (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 - Billing Of HCPCS Code E0986 (MOB)

Recently the Pricing, Data Analysis and Coding (PDAC) Contractor and the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received questions regarding HCPCS code E0986 Manual wheelchair accessory, push activated power assist, each.

E0986 is a push-rim activated power assist option for a manual wheelchair in which sensors embedded in specially designed wheels determine the force that is exerted by the beneficiary upon the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel. E0986 includes the two drive wheels/motors, batteries and battery charger. Only one unit of service should be billed per manual wheelchair.

Correct Coding - Palatal Lift Prosthesis - Joint DME MAC Publication (GEN)

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

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

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

Current Dental Terminology (CDT) D codes are not within DME MAC jurisdiction. Claims for D codes must be submitted to the local carrier. Claims for D codes submitted to the DME MAC will be denied as wrong jurisdiction.

Claims for palatal lift prostheses submitted to the DME MAC using other HCPCS NOC codes will be denied as incorrect coding.

Correct Coding - Vibration Therapy Devices - Joint DME MAC Publication (GEN)

Vibration therapy is the application of a vibratory stimulation to the body. It can be applied in a variety of ways, ranging from whole-body vibration to stimulation of local areas such as joints, hands, face, etc. (not all-inclusive). It is promoted as a treatment for numerous conditions such as arthritis, joint swelling, headache, neuropathic pain, restless legs, etc. (not all-inclusive).

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the Medicare program. This is true even though the item has some remote medically related use. Vibration devices are considered to be massage modalities. As such they are not eligible to be classified as Durable Medical Equipment. Claims for these items must be coded using:

A9270: Non-Covered Item or Service

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

Coverage and Correct Coding of Continuous Glucose Monitoring Devices - Joint DME MAC Publication (SPE)

Continuous glucose monitoring (CGM) devices measure glucose in the interstitial fluid, not capillary blood, providing interstitial glucose readings every few minutes. CGM systems are composed of several components - disposable sensors that are inserted in the subcutaneous tissue, a transmitter that relays information to the receiver, and a receiver where the information is displayed.

Coverage

Current CGM systems are FDA-approved only as a secondary source for glucose monitoring. According to the FDA labeled indications, all CGM device readings must be confirmed with a capillary blood glucose monitor and users are cautioned against making insulin dosage changes based solely on CGM system determinations. Consequently, CGM devices are considered precautionary equipment. The Medicare Durable Medical Equipment Benefit excludes precautionary items from coverage; therefore, claims for CGM systems are denied as statutorily non-covered, no benefit.

Medicare covers necessary supplies used with covered items. When the base item is non-covered, the related supplies are also not covered. Claims for supplies used with CGM systems are denied as statutorily non-covered, no benefit.

Coding

CGM systems are provided either as stand-alone systems or integrated into an insulin pump. For stand-alone systems and related supplies, use the following HCPCS codes:

A9276 - SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY

A9277 - TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

A9278 - RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

CGM capability that is integrated into an insulin pump is considered as included in the coding for the infusion pump. Additional supplies necessary for CGM use are likewise included in the code for the infusion pump supplies. There is no separate or additional coding for CGM functions. The following HCPCS codes are used for insulin pumps and related supplies:

E0784 - EXTERNAL AMBULATORY INFUSION PUMP, INSULIN

A4221 - SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)

K0552 - SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH

Separately billing for a CGM system integrated into an infusion pump or related supplies is incorrect. Claims for separate billing will be denied as unbundling.

Refer to the LCDs and related Policy Articles for Glucose Monitors and External Infusion Pumps for additional information.

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)

Note: *The following bulletin article, published by the DME MACs in February, 2014 is being revised to update the Coding Verification Review (CVR) information. The remainder of the article is unchanged.*

The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination for Speech Generating Devices (IOM 100-3 §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 repairs (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 **December 1, 2014**, the only products which may be billed to Medicare for SGDs 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. A written coding verification is not needed in order to submit claims to Medicare for SGDs furnished prior to **December 1, 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/

Electronic Health Records and Addenda - July 2014 (GEN)

Dear Physician,

Recent DME MAC claim review experience has highlighted an issue with electronic health records (EHR) and documentation of additional clinical information that occurs following the initial beneficiary visit. The Centers for Medicare & Medicaid Services (CMS) refers to this additional information as amendments; however, similar principles as discussed below apply to corrections and delayed entries.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) often request your patient's medical record in support of their claim to Medicare. When providing records, particularly those that have been amended or corrected, it is critical that you provide both the original note and any subsequent amendments or corrections to the original note.

For reference, the Medicare *Program Integrity Manual* (Internet-only Manual 100-08), Chapter 3, Section 3.3.2.5 provides the following guidance on amendments, corrections and delayed entries:

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. *Clearly and permanently identify any amendment, correction or delayed entry as such; and,*
2. *Clearly indicate the date and author of any amendment, correction or delayed entry; and,*
3. *Not delete but instead clearly identify all original content.*

The above record keeping principles apply to all medical records, whether electronic or handwritten; however, the *Program Integrity Manual* also specifically addresses amendments, corrections and delayed entries in EHRs with the following instructions:

Medical record keeping within an EHR deserves special considerations; however, the principles above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. *Distinctly identify any amendment, correction or delayed entry; and,*
b. *Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.*

The manner in which an EHR system notates amendments and corrections can differ by software vendor. Many electronic health records can be configured to deliver documentation which meets these requirements. If you are uncertain about the reports which are generated by your EHR, you are encouraged to consult with your organization's EHR project team to ensure that these reports are being produced properly. In addition, you and your staff are encouraged to be careful when preparing your response to a record request. Often in reviewing claim documentation, the Medical Review staff receives only the amended record with no indication of what was amended or corrected, when the change occurred or by whom the change was made. Failure to provide a complete medical note or a record with changes inconsistent with the CMS manual instructions may result in a claim denial and the inability for your DMEPOS supplier to provide the necessary equipment to accomplish your treatment goals.

Sincerely,

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

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

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

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

Electronic Health Records and Addenda - Joint DME MAC Publication (GEN)

Recent DME MAC claim review experience has highlighted an issue with electronic health records (EHR) and documentation of additional clinical information that occurs following the initial beneficiary visit. The Centers for Medicare & Medicaid Services (CMS) refers to this additional information as amendments; however, similar principles as discussed below apply to corrections and delayed entries. Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be mindful of the record keeping principles detailed below when providing records during the course of an audit request. Specifically, suppliers must ensure that if providing a medical record that has been amended or corrected, that the original medical record note is also provided to the requesting entity.

The Medicare *Program Integrity Manual* (Internet-only Manual 100-08), Chapter 3, Section 3.3.2.5 provides the following guidance on amendments, corrections and delayed entries:

Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, and ZPICs containing amendments, corrections or addenda must:

1. *Clearly and permanently identify any amendment, correction or delayed entry as such; and,*
2. *Clearly indicate the date and author of any amendment, correction or delayed entry; and,*

3. *Not delete but instead clearly identify all original content.*

The above record keeping principles apply to all medical records, whether electronic or handwritten; however, the *Program Integrity Manual* also specifically addresses amendments, corrections and delayed entries in EHRs with the following instructions:

Medical record keeping within an EHR deserves special considerations; however, the principles above remain fundamental and necessary for document submission to MACs, CERT, Recovery Auditors, and ZPICs. Records sourced from electronic systems containing amendments, corrections or delayed entries must:

a. Distinctly identify any amendment, correction or delayed entry; and,
b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

The manner in which an EHR system notates amendments and corrections can differ by software vendor; therefore, suppliers of (DMEPOS) must be careful when preparing their response to a record request and provide both the original record and any amendments that were made to the original note. Often in reviewing claim documentation, the Medical Review staff receives only the amended record with no indication of what was amended or corrected, when the change occurred or by whom the change was made. Failure to provide the complete record or a record with changes inconsistent with the CMS manual instructions may result in claim denial.

Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding – Revised - Joint DME MAC Publication (SPE)

Effective: August 1, 2014

In April 2003 the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) establishing coverage for functional electrical stimulation (FES) to enable spinal cord injured (SCI) patients to walk (see *National Coverage Determinations Manual* 100-3 Chapter 1, Part 2, Section 160.12).

Functional electrical stimulation is a technique that uses electrical impulses to activate paralyzed or weak muscles in precise sequence. The FES device transmits these electrical impulses via surface electrodes in the same manner as neuromuscular electrical stimulation (NMES). For example, through selective and sequential stimulation of various lower extremity muscle groups, FES can enable spinal cord injured (SCI) patients to walk.

Coverage of NMES (other than FES) to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. There has been no change in coverage criteria when NMES is used to treat disuse atrophy.

Coverage of FES

Medicare will consider coverage of FES for SCI patients who have completed a training program consisting of at least 32 physical therapy sessions with the device, over a period of three months.

Coverage for FES to enhance walking will be limited to SCI patients with diagnosis ICD-9 code 344.1 Paraplegia - paralysis of both lower limbs, or (when implemented) one of the following ICD-10 codes: G04.1 Tropical spastic paraplegia, G82.21 Paraplegia, complete, G82.22 Paraplegia, incomplete, and with all of the following characteristics:

1. Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve); and,
2. Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently; and,
3. Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction; and,
4. Persons that possess high motivation, commitment and cognitive ability to use such devices for walking; and,
5. Persons that can transfer independently and can demonstrate standing independently for at least three minutes; and,
6. Persons that can demonstrate hand and finger function to manipulate controls; and,

7. Persons with at least six-month post recovery spinal cord injury and restorative surgery; and,
8. Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and,
9. Persons who have demonstrated a willingness to use the device long-term.

FES used to enhance walking for SCI patients with any of the following conditions, will not be covered:

1. Presence of cardiac pacemakers;
2. Severe scoliosis or severe osteoporosis;
3. Irreversible contracture;
4. Autonomic dysreflexia; or
5. Skin disease or cancer at area of stimulation

Indications for FES other than to enable SCI patients to walk will be denied as not medically necessary.

The only settings where therapists with the sufficient skills to provide these services are employed are inpatient hospitals, outpatient hospitals, comprehensive outpatient rehabilitation facilities and outpatient rehabilitation facilities. The physical therapy necessary to perform this training must be part of a one-on-one training program.

HCPCS Coding

Two codes are used to bill for FES:

E0764 FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM

E0770 FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED

Note that HCPCS codes E0764 and E0770 represent the "entire system" for the FES devices. Therefore, individual components such as walkers, crutches or other supplies must not be billed separately.

Manufacturers of products billed with code E0770 must have the code(s) verified by the Pricing, Data Analysis, and Coding (PDAC). Currently, the only products that are coded E0770 are:

- WalkAide (Innovative Neurotronics)
- Odstock ODFS Pace FES System (Odstock Medical/Boston Brace)
- NESS L300 and H200 devices (Bioness)

Code E0764 does not require code verification by the PDAC; however, currently the only product that is coded E0764 is the Parastep I (Sigmedics).

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/

Documentation Requirements

For E0770 to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted to the DME MAC. This order must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DME MAC upon request. If the supplier bills for this item without first receiving the completed order, the item will be denied as not medically necessary. Items billed to the DME MAC before a signed and dated order has been received by the supplier must be submitted with an EY modifier (No physician or other health care provider order for this item or service) added to each affected HCPCS code.

If all the above criteria for coverage are met, HCPCS codes E0764 and E0770 must be billed with a KX modifier (REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET). If all the coverage criteria listed above are not present, a KX modifier must not be added to the code.

The diagnosis code that describes the condition(s) requiring the use of FES must be added to the claim.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS
Effective for prescriptions dated on or after July 1, 2013

ACA 6407 contains provisions that are applicable to certain specified items in this NCD. The specified items are:

E0764 FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM

Prescription Requirements - Written Orders Prior to Delivery

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS code E0764. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. See below for information about the statutory requirements associated with a WOPD.

Specific Documentation Requirements

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items; therefore, a WOPD is required. Refer to the section below for information about these statutory requirements.

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

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

Statutory Requirements

Face-to-Face Visit Requirements

As a condition for payment, Section 6407 of the *Affordable Care Act* (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the WOPD.
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier
- When required by state law

The first bullet, “For all claims for purchases or initial rentals”, includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

Prescription Requirements

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the DMEPOS supplier's possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary's name
- Physician's Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However, the prescriber must:

- Verify that the in-person visit occurred within the 6-months prior to the date of their prescription; and,
- Have documentation of the face-to-face examination that was conducted; and,
- Provide the DMEPOS supplier with copies of the in-person visit records.

Date And Timing Requirements

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Claim Denial

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily noncovered - failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

Home Oxygen Initial Qualification Testing – Revised - June 2014 (OXY)

Dear Physician,

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

Timing of Physician Visit and Testing

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

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

Qualifying Test Results

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

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

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

Qualification Tests

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

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

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

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

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

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

Chronic Stable State (CSS)

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

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

Sincerely,

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

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

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

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

LCD and Policy Article Revisions Summary for July 24, 2014 (GEN)

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

Immunosuppressive Drugs

LCD

Revision Effective Date: 10/01/2014
DOCUMENTATION REQUIREMENTS:
Revised: Continued Need and Use Sections

Pressure Reducing Support Surfaces - Group 2

Policy Article

Revision Effective Date: 10/01/2014
CODING GUIDELINES:
Revised: E1399 Code Guidelines

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 June 19, 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.

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 01/01/2014 (June 2014 Publication)
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Statement noting that Aprepitant is currently the only FDA approved NK-1 antagonist
DOCUMENTATION REQUIREMENTS:
Added: Statement about adding V58.11 to each claim for codes J8501 and Q0181

Power Mobility Devices

Policy Article

Revision Effective Date: 10/01/2013 (June 2014 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Clarification: The face to face treating physician and prescribing physician requirements under ACA 6407 (Requirements effective 07/01/2013)
CODING GUIDELINES:
Clarification: E0986 is all inclusive

Wheelchair Options/Accessories

LCD

Revision Effective Date: 07/01/2013 (June 2014 Publication)
MISCELLANEOUS:
Removed: Requirement for accessories to be billed on the same claim as base

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 Summary for June 12, 2014 - Drafts Released to Final (GEN)

The following three draft Local Coverage Determinations and Policy Articles have been finalized:

- Transcutaneous Electrical Joint Stimulation Devices (TEJSD)
- Tumor Treatment Field Therapy (TTFT)
- Vacuum Erection Devices (VED)

Each of these medical policies will be effective for claims with dates of service on or after August 01, 2014. The notice period start date is June 12, 2014 and the notice period end date is July 31, 2014.

Please review each entire LCD and related Policy Article for coverage, coding and documentation requirements. Also review the Response to Comments Summary attached to each LCD.

Orthoses/Prostheses - Coding for Professional Services/Fabrication Supplies (O&P)

HCPCS codes L4205 (Repair of orthotic device, labor component, per 15 minutes) and L7520 (Repair of prosthetic device, labor component, per 15 minutes) may only be billed for time involved with the actual repair of an orthosis or prosthesis, respectively, or for medically necessary adjustments made more than 90 days after delivery.

HCPCS codes L4205 and L7520 must not be used to bill for time involved with other professional services including, but not limited to:

- Evaluating the patient
- Taking measurements, making a cast, making a model, use of CAD/CAM
- Making modifications to a prefabricated item to fit it to the individual patient
- Follow-up visits
- Making adjustments at the time of or within 90 days after delivery

Reimbursement for these services is included in the allowance for the HCPCS codes which describe the orthosis/prosthesis.

Similarly, HCPCS codes L4210 (Repair of orthotic device, repair or replace minor parts) and L7510 (Repair of prosthetic device, repair or replace minor parts) must not be used for casting supplies or other materials used in the fitting or fabrication of an orthosis/prosthesis.

If a supplier decides to submit a claim for services/items that are included in the allowance for the orthosis/prosthesis, HCPCS code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used. HCPCS code L9900 is denied as not separately payable.

Services or supplies associated with the provision of plaster or fiberglass casts or splints are in the jurisdiction of the local carriers and fiscal intermediaries. Claims for these items may not be submitted to the DME MAC.

Orthoses: Replacement of Components Clarification (O&P)

The allowance for a prefabricated orthoses includes all components provided at the time of initial issue including, but not limited to, soft interfaces, straps, closures, etc. Replacements of components of covered orthoses are covered if the original component is no longer functional due to wear and cannot be repaired. Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are not covered.

Some replacement items have unique HCPCS codes. For example, replacement soft interfaces used with ankle contracture orthoses or foot drop splints are billed with HCPCS codes L4392 and L4394, respectively. One unit of service of the replacement interface HCPCS code is covered no more often than once every 6 months. Replacement components that do not have a unique HCPCS code must be billed with a "not otherwise specified" code - L1499, L2999, or L3999, whichever is applicable. The claim must include a description of the component provided, the reason for replacement, and the HCPCS code or narrative description of the base orthosis.

Note: *HCPCS codes L4040-L4055 do not describe replacement soft interfaces used with contracture orthoses.*

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (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/

Policy Reminder - Positive Airway Pressure (PAP) Devices - Continued Coverage beyond the First Three Months of Therapy - Joint DME MAC Publication (SPE)

A review of recent appeals information has identified denials associated with demonstrating compliance with the PAP Local Coverage Determination (LCD) requirements for continued coverage after the initial three months rental. This article is intended as a review of those criteria.

General requirements

PAP is covered for beneficiaries with obstructive sleep apnea (OSA). The presence of OSA is documented by clinical evaluation and sleep testing. Refer to the LCD for a discussion of the requirements necessary to establish coverage with a diagnosis of obstructive sleep apnea.

Once the diagnosis of OSA is established, the initial three rental months are covered. But by the end of the first three months, there are additional requirements that must be met in order for equipment rental and supply payments to continue. Compliance with these requirements must be documented in the beneficiary's medical record. When the requirements are not met, coverage for more than the first three months is not possible.

There are two requirements for continued coverage. They are:

1. The treating physician must have an in-person visit with the beneficiary no sooner than the 31st day but no later than the 91st day after initiating therapy, conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.
2. There must be objective evidence of the beneficiary's adherence to the use of the PAP device. Adherence to therapy is defined as use of PAP $\geq$4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. This information must be reviewed by the treating physician and included in the medical record.

Failure to Meet Payment Requirements

If the above criteria are not met, continued coverage of a PAP device and related accessories beyond the first three months is not possible. Claims for the fourth month and beyond will be denied as not reasonable and necessary.

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

Beneficiaries who fail the initial 12 week trial are eligible to re-qualify for a PAP device but must have both:

1. Face-to-Face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and,
2. Repeat sleep test in a facility-based setting (Type 1 study).This may be a repeat diagnostic, titration or split-night study.

Change in Equipment

If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial, substitution of an E0470 does not change the length of the trial unless there is less than 30 days remaining in the trial period. If more than 30 days remain in the trial period, the clinical re-evaluation would still occur between the 31st and 91st day following the initiation of an E0601 and objective documentation of adherence on the E0470 would need to occur prior to the 91st day following initiation of the E0601. If less than 30 days remain in the trial period, the clinical re-evaluation and objective documentation of adherence must occur before the 120th day following the initiation of the E0601.

If an E0601 device was used for more than 3 months and the beneficiary was then switched to an E0470, the clinical re-evaluation must occur between the 31st and 91st day following the initiation of the E0470. There would also need to be documentation of adherence to therapy during the 3 month trial with the E0470.

Documentation Requirements

Both PAP devices (E0601 and E0740) are subject to the *Affordable Care Act* Section 6407 (ACA) requirements. The ACA requires that there be an in-person encounter with a healthcare provider sometime in the 6 months preceding the prescribing of the item. This visit must address some element of the underlying condition(s) that are the basis for the need for the item. The prescription must be a properly completed Medicare "Detailed Written Order". This document is often referred to as a "Written Order Prior to Delivery (WOPD)". This WOPD and the documentation of the Face-to-Face visit must be in the supplier's file before delivery of the item can occur.

Suppliers are reminded that all Medicare coverage and documentation requirements for the PAP LCD also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

Refer to the Positive Airway Pressure Devices LCD and related policy article for additional information about coverage, coding and documentation.

Positive Airway Pressure Device and Respiratory Assist Device - Nasal Interfaces and Liners – Revised (SPE)

Effective: August 1, 2014

There are two types of nasal interfaces that are used with a Positive Airway Pressure (PAP) device or a Respiratory Assist Device (RAD) - a nasal mask and cannula-type interface.

Both of these types of products are coded A7034 (NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP). HCPCS code A7034 includes the soft interface at initial issue.

HCPCS codes A7032 (CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH) and A7033 (PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR) describe replacement soft interfaces. HCPCS code A7032 is used for a nasal mask interface that goes around the nose, but not into the nostrils. The unit of service for this HCPCS code is "each." HCPCS code A7033 is used for a nasal cannula-type interface. This interface extends a short distance into the nostrils. The unit of service for this code is "pair." For some products, there are two physically separate cushions or "pillows" - one for each nostril. Two cushions/pillows (i.e. "pair") equal one unit of service of HCPCS code A7033. For other products, the interface is a single piece with two protrusions that extend into the nostrils. One of these interfaces equals one unit of service of HCPCS code A7033.

Liners are not interfaces for use with a PAP mask. Liners are products placed between the patient's skin and the PAP mask interface and are made of cloth, silicone or other materials. These are not considered "interfaces" as defined in the PAP Local Coverage Determination (LCD) and related Policy Article, as described above. Liners must not be billed as replacement interface for a PAP mask using codes such as A7031 (Face mask interface, replacement for full face mask, each) or A7032 (Cushion for use on nasal mask interface, replacement only, each).

A liner used in conjunction with a PAP mask is considered a comfort and convenience item and must be coded A9270 (Noncovered item or service). There is no additional payment for liners used with a PAP mask (see *Medicare Benefit Policy Manual* 100-2 Chapter 15 Section 110.1).

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (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/

Proof of Delivery - Requirements for Signature and Date - Joint DME MAC Publication (GEN)

Auto-filling the date of delivery on delivery documentation or Proof of Delivery (POD) is a common business practice for many DMEPOS suppliers. Upon delivery, the Medicare beneficiary or designee is required to review the POD and must provide his or her signature, which signifies knowledge, approval and acceptance of the delivery. The *Program Integrity Manual* (PIM) chapter 4, section 4.26.1 "Proof of Delivery and Delivery Methods" does not state who may enter the date of delivery, but indicates that the date of signature must be the date in which the item was actually delivered. According to the PIM "….the date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee…." If the delivery documentation is signed by the beneficiary's designee, the PIM also recommends noting the relationship of the designee to the beneficiary on the document.

Based on these instructions, the POD delivery date element is not required to be personally filled in by the beneficiary/designee. The date of delivery may be entered by the beneficiary, designee or the supplier. The date entered must be the actual date of delivery.

In the event that the supplier's delivery documents have both a supplier entered date and the beneficiary or designee signature date on the POD document, the beneficiary/designee entered date is considered to be the delivery date and thus the date of service.

Reminder - Oxygen Equipment and Contents Delivery (OXY)

Suppliers are reminded that they cannot require a beneficiary to pick up oxygen equipment and contents at the supplier's location or a central dispensing facility. Requiring a beneficiary pick up their oxygen equipment and contents is a violation of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Standards (42 CFR 424.57(c)) which states:

> *12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.*

Delivery and service are an integral part of oxygen and durable medical equipment (DME) suppliers' costs of doing business. As such, these costs have already been accounted for in the calculation of the fee schedules.

When the DME MACs have knowledge of suppliers requiring beneficiaries to pick up equipment, a referral will be made to the National Supplier Clearinghouse for further investigation of the Supplier Standard violation.

Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (O&P)

Historical Review Results

A widespread complex medical review was performed for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This review resulted in a Charge Denial Rate (CDR) of 50.1%. A summary of findings were published on the NHIC, Corp. Website on April 24, 2014. Based on this result, a widespread prepayment review was continued.

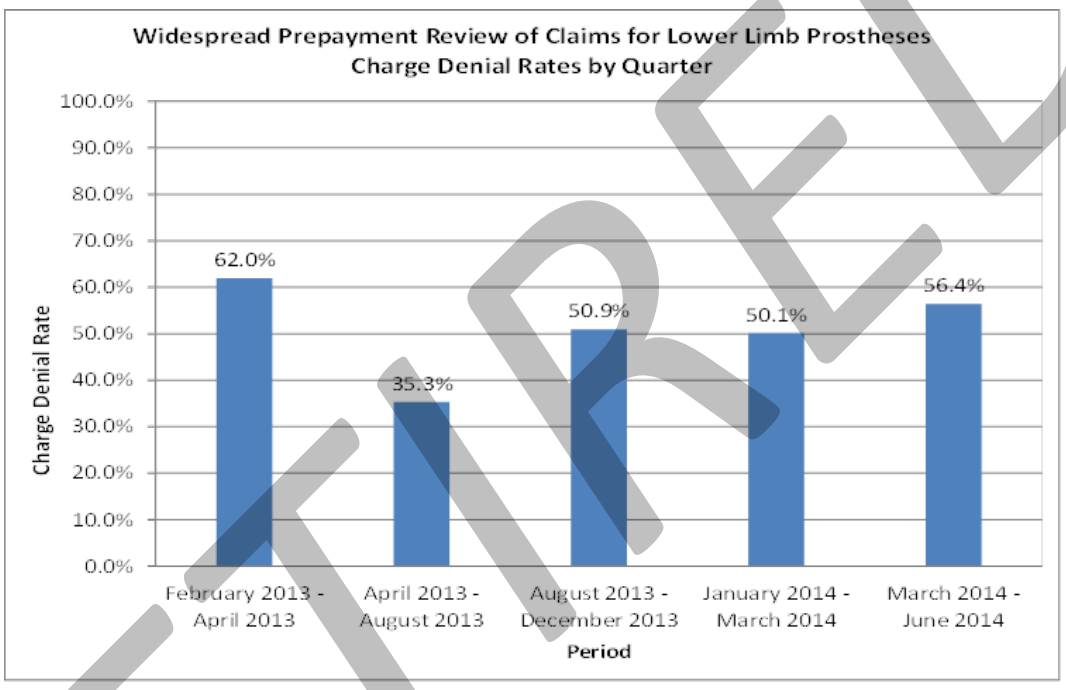
Current Review Results

DME MAC Jurisdiction A has completed a widespread prepayment complex review of claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided.

The review involved prepayment complex medical review of 201 claims submitted by 114 suppliers for claims processed March 21, 2014 to June 10, 2014. Responses to the Additional Documentation Request (ADR) were not received for 22 (11%) of the claims. For the remaining 179 claims, 72 claims were allowed and 107 were denied resulting in a claim denial rate of 60%. 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 56.4%.

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

- 28.7% of the denied claims had no medical record information submitted.

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

- 21.7% of the denied claims had clinical records submitted but the records did not justify the functional level of the billed item.

Proof of delivery

- 3.5% of the denied claims were missing the proof of delivery. Proof of Delivery was missing items delivered; items must be documented with a narrative description or a manufacturer name and model number.

Claim Examples

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

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed.

Missing: The prosthetist's evaluation/assessment and clinical documentation detailing the functional levels of the items billed.

Example 2:

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

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

Example 3:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items dispensed, treating physician's signature and date, and the start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed; and the prosthetist's evaluation/assessment documentation detailing the functional levels of 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.

Next Step

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

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

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

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

Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- The *DME MAC Jurisdiction A Supplier Manual* (Chapter 10: Includes Standard Documentation Requirements)
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/mobile/index.html

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

- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses
  (posted 06/14/2014, 10/25/2013, 01/21/2014, 04/24/2014)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Results of Widespread Prepayment Probe for Lower Limb Prostheses - Posted November 30, 2011
  http://www.medicarenhic.com/viewdoc.aspx?id=353

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

Historical Review Results

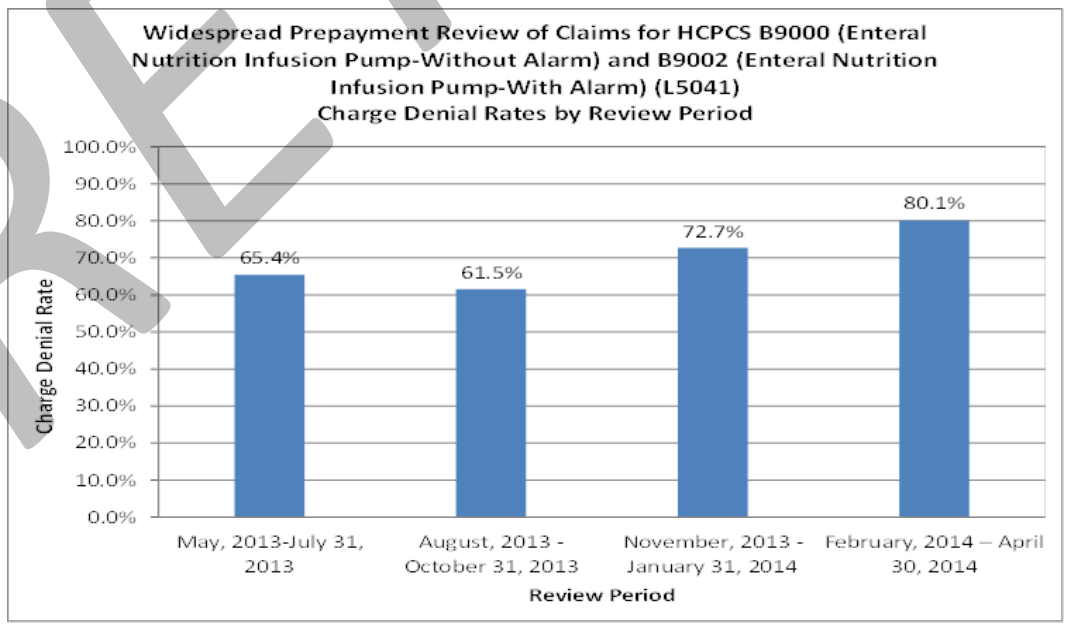
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed November 01, 2013 thru January 31, 2014 and resulted in a 72.7% 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 February 01, 2013 through April 30, 2014.

The review involved prepayment complex medical review of 1242 claims submitted by 128 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 221 (18%) of the claims. For the remaining 1021 claims, 196 claims were allowed and 825 were denied/partially denied resulting in a claim denial rate of 81%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 80.1%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Clinical Documentation Issues

- 30% of the denied claims did not have any medical record documentation submitted.
- 18% 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
  c) a specialty formula ordered, with no documentation to support need

  Note: *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- <1% of the claims denied for statutory denial - did not meet prosthetic benefit requirement. Beneficiary able to tolerate oral nutrition.

Proof of Delivery

- 31% of the denied claims had no Proof of Delivery (POD).
- 19% of the claims had incomplete delivery information.
  - No proof of receipt by the beneficiary.
  - Unable to match and verify through name, use of order numbers, and/or conflicting tracking numbers

Detailed Written Order Issues

- 20% of the denied claims had missing detailed written orders.
- 12% of the denied claims had incomplete detailed written orders
  - Date of the detailed order was incomplete (missing month or year)
  - Of the denied claims, physician signature could not be authenticated

DME Information Form

- 11% missing DME Information Form
- 2% missing Enteral Pump HCPCS code

Claim Examples

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

Example 1:

Received: Detailed physician order, medical documentation, delivery ticket with signature and date
Missing: DME Information Form missing Enteral Pump HCPCS code

Example 2:

Received: Detailed physician order, DIF, delivery ticket with signature and date
Missing: Medical documentation that supports prosthetic benefit

Example 3:

Received: Delivery ticket with date of signature
Missing: Physicians detailed written order, medical documentation, DIF

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for B9000 and B9002. DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews. One assessment is the Compliance Improvement Program (CIP), which measures suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs).

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

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

Educational References

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

- Enteral Nutrition (L5041) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (posted 06/23/2013, 03/08/2013, 07/20/2012, 05/11/2012, 12/22/2012, 09/20/2011, and 03/11/2011)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
  http://www.medicarenhic.com/dme/supmandownload.aspx
- CERT Physician Letter - Enteral Nutrition
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/selfservice.aspx
- Frequently Asked Questions (search word Enteral)
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- Enteral Nutrition Supply Kits - Coverage Reminder
  http://www.medicarenhic.com/viewdoc.aspx?id=563
- 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 November 01, 2013 through January 31, 2014 and resulted in a Charge Denial Rate (CDR) of 74.1%.

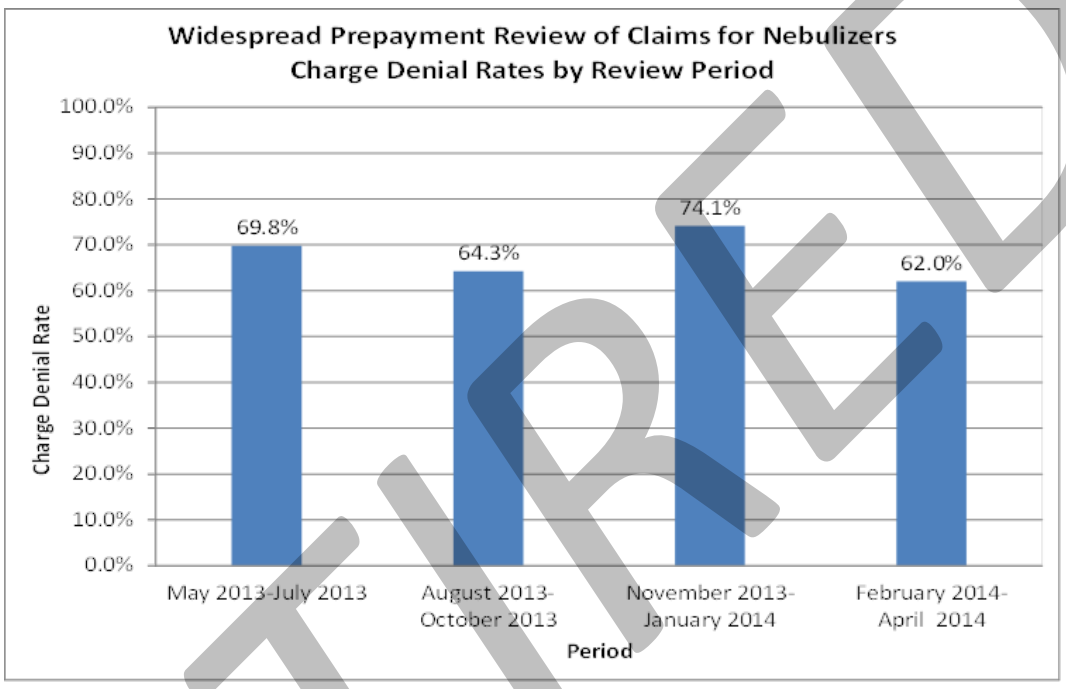
Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from February 01, 2014 through April 30, 2014. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 1164 claims submitted by 508 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 231 (20%) of the claims. For the remaining 933 claims, 197 claims were allowed (21%) and 736 were denied/partially denied resulting in a claim denial rate of 79%. 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 62%.

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

- 25% of the denied claims were missing clinical information to support medical necessity.
  - No medical records were submitted
- 26% of the denied claims had insufficient or incomplete clinical documentation. The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer
    - Clinical documentation submitted did not mention a payable medical condition
    - Clinical documentation submitted had no mention of need for a nebulizer
  - Illegible copy of documentation submitted
  - Physician signature did not meet signature requirements including:
    - Missing physician's handwritten or electronic signature
    - Illegible physician signature with no printed name to verify against and no signature log submitted
    - Unsigned typed note with just physician's typed name

Detailed Written Order Issues

- 3% of the denied claims were missing the detailed written order.
- 21% of the denied claims had an incomplete or invalid detailed written order. The following are specific issues identified:
  - Illegible copy of order

  - Start date after the date of service
  - Physician signature date was after the claim was submitted
  - Physician signature did not meet signature requirements including:
    - Illegible physician signature
    - Unable to authenticate physician signature with printed name and/or no signature log submitted.
  - Incompatible combination of items ordered
- 10% of the denied claims (with a date of service 01/01/2014 or after) had an incomplete or invalid Written Order Prior to Delivery (WOPD). The following are specific issues identified:
  - Missing the Physician's NPI number
  - Physician signature date was after the supplies were delivered
  - Insufficient evidence (i.e. date stamp, fax date, etc) within the claim to show that the supplier received the Written Order prior to delivering the supplies
  - Incompatible combination of items ordered

Proof of Delivery Issues

- 5% of the denied claims were missing proof of delivery.
- 23% of the denied claims had an incomplete or invalid proof of delivery.
  The following are specific issues identified:
  - Illegible copy of proof of delivery
  - Missing sufficiently detailed description to identify the item(s) being delivered
  - Missing beneficiary signature and date of signature when item(s) are delivered directly by the supplier to the beneficiary
  - Nebulizer (first month rental) delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier (Method I)
  - Nebulizer (first month rental) shipped either before or after the date of service when the item(s) is shipped via a shipping service or delivery service (Method II) directly to a beneficiary

Claim Examples

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

Example 1:

Received: The Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature, clinical notes and proof of delivery

Missing: The WOPD is missing the physician's NPI number. The date of the physician's signature on the WOPD is dated after the supplies were delivered. Insufficient evidence (i.e. date stamp, fax date, etc.) within the claim submitted to show that the supplier received the WOPD prior to delivering the supplies.

Example 2:

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

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

Example 3:

Received: Detailed written order with: beneficiary name, description of items to be dispensed, physician's legible signature, and date of signature.

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

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 06/28/2013, 09/13/2013, 12/12/2013, 03/20/2014)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Monthly CERT Error examples
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Frequently Asked Questions (search word "nebulizer")
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- Face-to-Face and Written Order Requirements for High Cost DME - Dear Physician Letter
  http://www.medicarenhic.com/dme/mobile/index.html

Results of Widespread Prepayment Review of Claims for L0631 and L0637, Lumbar-Sacral Orthoses (L11470) (O&P)

Historical Review Results

DME MAC A Medical Review continues to review Lumbar-Sacral Orthoses (L0631 and L0637) based upon results of initial findings. The initial findings covered a period from July 16, 2013 - September 27, 2013 and resulted in a Charge Denial Rate of 76.8%.

Current Review Results

The DME MAC Jurisdiction A has completed the prepayment probe review of claims for Lumbar-Sacral Orthoses;

- HCPCS code L0631 is a Lumbar-Sacral Orthoses, sagittal control with rigid anterior and posterior panels, posterior extends from sacroccoccygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment.
- HCPCS code L0637 is a Lumbar-Sacral Orthoses, sagittal-cornal control with rigid anterior and posterior fram/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment. This probe was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 899 claims submitted by 89 suppliers. These claims were reviewed from January 13, 2014 - April 13, 2014. Responses to the Additional Documentation Request (ADR) were not received for 170 (19%) of the claims. For the remaining 729 claims, 104 claims were allowed and 617 were denied resulting in a claim denial rate of 85%. 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 83.3%.

Primary Reasons for Denial

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

Detailed Written Orders Issues

- Denied claims were missing a Detailed Written Order for L0631/L0637 being billed (15%)
- Denied claims included an incomplete order (7%)
    - Detailed Written Orders submitted were not legible (2%)
    - Detailed Written Orders missing start date and/or signature date (4%)
    - Detailed Written Orders did not list a beneficiary name (1%)

Medical Record Documentation Issues

- Denied claims missing the clinical documentation to support medical necessity (13%)
- Denied claims due to no pertinent clinical documentation (4%)
    - Clinician notes submitted show a different beneficiary than stated within the claim submitted (3%).
    - 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 (17%).
    - Medical documentation was not authenticated by the clinician conducting the exam (1%).

Proof of Delivery Issues

- Denied claims were missing the proof of delivery (23%)
- Proof of Delivery included delivery tickets not having required elements (20%)
    - Delivery ticket did not include signature of beneficiary or Beneficiary's representative; unable to determine beneficiary received items billed (13%)
    - Delivery ticket dates do not match shipping/received dates for items as defined within the LCD L11470 (7%)

Claim Examples

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

Example 1:

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

Missing: Proof of delivery, with all of the required elements. Claim History Verification demonstrated beneficiary had received same L0631 within the last 5 years.

Example 2:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items dispensed, treating clinician's signature and date, and the start date of order. Clinical documentation was also submitted.

Missing: Proof of delivery, with all of the required elements. The submitted clinical documentation did not support the medical necessity.

Example 3:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, date of clinician's signature and start date of order. Proof of delivery, with all of the required elements.

Missing: Detailed Written Order is missing practitioner signature. Clinical documentation to support medical necessity of item which includes name of beneficiary, date of appointment, and clinician's signature.

Next Step

Based upon the results of initial prepayment review, DME MAC A will continue to review claims for Lumbar- Sacral Orthoses, HCPCS codes L0631/L0637.

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

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

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

Educational References

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

- LCD for Spinal Orthoses: TLSO and LSO (L11470)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- The *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - additional information regarding general coverage and documentation requirements)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Prepay Probe for Lumbar-Sacral Orthoses
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/dmerccertrec.aspx

Supplier Exit from Oxygen Equipment Business – Revised - Joint DME MAC Publication (OXY)

Note: *This article was formerly titled, "Supplier 'Abandonment' of Beneficiaries and Oxygen Equipment"*

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 exits the Medicare oxygen business, whether voluntarily or due to revocation of billing privileges, 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 remainder 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 are strongly encouraged to provide a minimum of thirty (30) days notice to the beneficiary of their intention to no longer provide oxygen therapy services. This should be provided in writing and may take one of two forms:

- 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,
- 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.

Suppliers exiting through revocation are not subject to the notification requirements suggested above.

Obligations of New Supplier

For suppliers who receive beneficiaries from providers who have exited the Medicare oxygen business, claims for replacement equipment must:

- For the first month claim, append the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,
- Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.
    - When submitting claims electronically, use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 5010A1 electronic claim format.
    - When billing using the Form CMS-1500 paper claim, include the narrative information in item 19 of the claim form.
    - Home health agencies billing using the UB-04 paper claim may report this information in Form Locator 80 (Remarks).

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 include:

- 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; or,
- Attestation statement from the beneficiary indicating that the beneficiary (or their caregiver) has attempted to contact their existing supplier and has been unable to obtain service.

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.

Vacuum Erection Device - Coding Verification Review Requirement (O&P)

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) published a new Local Coverage Determination (LCD) for Vacuum Erection Devices effective for dates of service on or after August 01, 2014. The Vacuum Erection Devices LCD related Policy Article Coding Guidelines section contains additional guidance on the proper coding of products coded L7900 and L7902.

All products currently listed on the Pricing, Data Analysis, and Coding (PDAC) contractor web site with HCPCS codes L7900 or L7902 will be end dated effective October 31, 2014. Manufacturers will be required to submit a new coding verification application to the PDAC for review and assignment of the correct code for products currently coded as L7900 or L7902.

Effective for claims with dates of service on or after November 01, 2014, the only products which may be billed to Medicare using code L7900 or L7902 are those for which a written coding verification has been made by the PDAC contractor and are listed on the Product Classification List in the Durable Medical Equipment Coding System (DMECS) maintained on the PDAC web site, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code A9270. The PDAC coding verification application required for these products is the 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/

Widespread Prepayment Probe for HCPCS Code E0464 (Pressure Support Ventilator with Volume Control Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (e.g. Mask)) (SPE)

DME MAC JA will be initiating a widespread prepayment probe for claims submitted with HCPCS code E0464 (Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask).

This review is being initiated due to an increase in billing identified by data analysis.

Ventilators are classified in the Frequent and Substantial Servicing (FSS) payment category. The monthly rental payment for items in this pricing category is all-inclusive, meaning there is no separate payment by Medicare for any options, accessories or supplies used with a ventilator. In addition, all necessary maintenance, servicing, repairs and replacement are also included in the monthly rental. Claims for these items and/or services will be denied as unbundling. Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary.

The Centers for Medicare & Medicaid Services (CMS) *National Coverage Determinations Manual* Chapter 1, Part 4, and Section 280.1 stipulates “that ventilators are covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both positive/negative pressure types.”

Documentation must include the following:

1. Physician order for the item
2. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item(s) are met.
3. Proof of delivery.
4. Any other pertinent information that would justify payment for the item(s) provided.
5. Advanced Beneficiary Notice (ABN) if one was obtained, this must be submitted with the above requested documentation.

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

- Correct Coding and Coverage of Ventilators - Joint DME MAC Publication
  http://www.medicarenhic.com/viewdoc.aspx?id=2653

Provider Services Portal (PSP)

The Provider Services Portal (PSP) is an internet portal available to DME MAC A providers. PSP users can easily access beneficiary eligibility, claims information, DME same/similar and specific A, L & V HCPCS Look-up, reopening & redetermination submission and status, as well as print Remittances over the internet. The PSP is currently available for open enrollment. There is no charge to participate! For more information visit the DME MAC A PSP Home page.

Reopening and Redetermination Submission & Status - Now Available on our Provider Services Portal (PSP) (GEN)

NHIC DME MAC Jurisdiction A is pleased to announce our PSP now has the capability to submit and obtain status for reopenings and redeterminations via our free internet based portal. While reviewing claim status details, the new reopening and redetermination option allows you to create your forms and submit via the PSP. The PSP also allows for the submission of additional documentation to support your request. This option will decrease time and costs associated with submitting reopening and redetermination requests via fax or mail.

Don't miss out! If you are not yet signed up for our PSP you are missing a great opportunity to:

- Easily access patient eligibility and claim status
- Print a copy of a remittance
- Check for same/similar equipment history including A,L and V codes
- And now submit and obtain status for reopenings and redeterminations

We encourage you to enroll in our PSP and take advantage of this opportunity to increase efficiency via the use of our free web-based portal.

Interested DME MAC A Suppliers can obtain additional information and begin the enrollment process today at the following link:
http://www.medicarenhic.com/dme/pspinvite.aspx

Provider Services Portal (PSP) Announcement - New Functionality Added (GEN)

DME MAC Jurisdiction A is pleased to announce the PSP has expanded the search capability to include CPAP codes for 'A' HCPCS for same/similar Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) history via our free internet-based portal, the PSP. A chart to view the codes is available on the portal and can be found under the A, L and V search field. This new options will decrease the time necessary to contact a customer service representative directly to verify same/similar information for these codes. The PSP has also added the capability to submit and obtain status for reopenings and redeterminations. While reviewing claim status details, the new reopening and redetermination option allows you to create your forms and submit via the PSP. The PSP also allows for the submission of additional documentation to support your request. This option will decrease time and costs associated with submitting reopening and redetermination requests via fax or mail.

The PSP is accepting enrollments today & enrollment is free! Why should you enroll?

Do you want to check your claims online?
Do you need access to Medicare claims 24/7?
Do you need to check your patient's Medicare eligibility?
Do you need to print remittances?
Do you need to check your patient's history for same/similar HCPCS and specific A, L and V codes?
Do you submit reopenings and redeterminations?
Do you like fast results?

Interested DME MAC A Suppliers can obtain additional information and begin the enrollment process today at:
http://www.medicarenhic.com/dme/psphome.aspx

Sign up now!

Second Quarter 2014 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2014 are provided in the following table.

Note: *The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.*

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 - Rejected for relational field Information within the HCPCS	93,565	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.	23,746	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	22,603	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	16,053	The NPI submitted is not linked to the Submitter ID under which the claim file was sent. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site and return to CEDI for processing.
X222.380.2400.DTP03.080 - Invalid Information within the Future date and Date(s) of service	11,938	The service start/from date is greater than the date this claim was received.
X222.380.2400.DTP03.090 - Invalid Information within the Date(s) of service	11,293	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
X222.380.2400.DTP03.070 - Invalid information within the Date(s) of service	9,459	The number of services entered for this line is invalid. Capped rentals can only have one unit of service.
X222.351.2400.SV101-3.020 - This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	8,548	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.087.2010AA.NM109.030 - Invalid information in the Billing Provider's NPI	8,427	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.226.2300.HI01-2.030 - Invalid Information within the Primary diagnosis code	7,847	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.

Second Quarter 2014 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the second quarter of 2014. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from April through June 2014.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	29,712
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.	11,071
OA109, N104 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	10,821
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.	4,077
CO 16, MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,174
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.	1,563
CO 16, M79 Missing / incomplete / invalid charge	**Item 24F** - Did not complete or enter the appropriate charge for each listed service (submitted charges zero).	1,497
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,495
CO 16, MA130, M76 Missing / incomplete / invalid diagnosis or condition	**Item 21** - Claim/service lacks information with diagnosis code which is need for adjudication.	1,460
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.	1,116

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 June of 2014 chapters 1, 2, 3, 4, and 10 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

Updating Supplier Records (GEN)

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information must be reported in writing to the NSC within 30 days after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier must then verify their address with the NSC in writing.

Note: *A request to change your address should not be sent to DME MAC A since we cannot change supplier files.*

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms web site at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly Bulletins and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

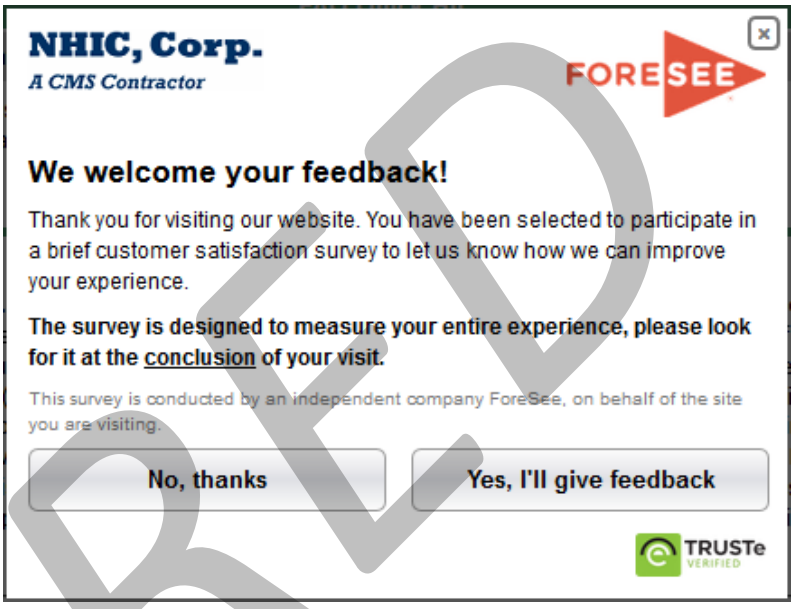
Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at http://www.medicarenhic.com/dme/listserve.html

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey

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.

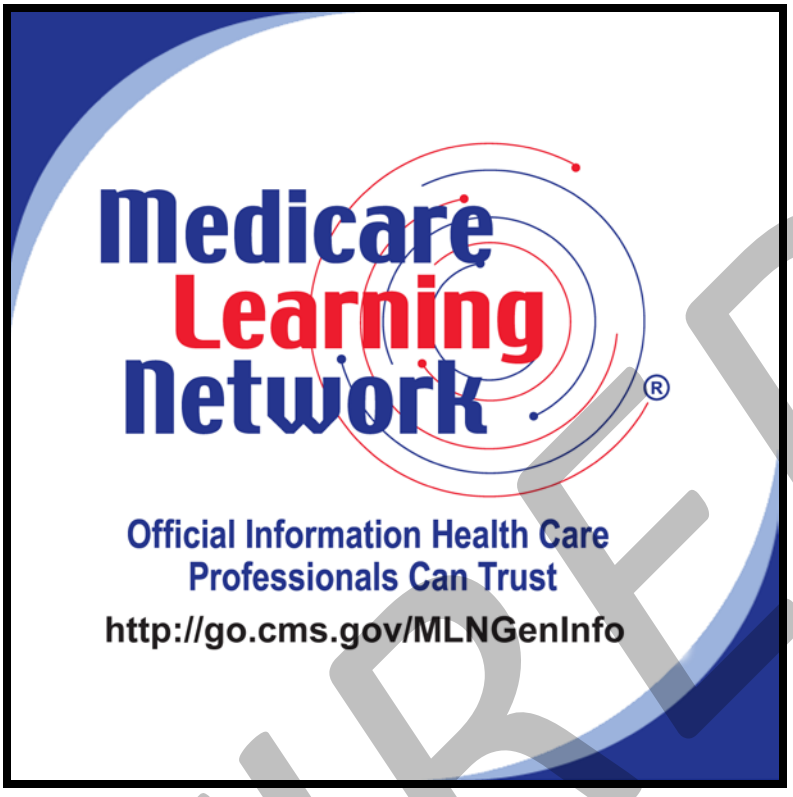
As our site is constantly changing, we would appreciate your input! We are listening... It is **your** feedback that makes those changes possible!



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!

First Means of Contact

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


Medicare
Learning
Network®
Official Information Health Care
Professionals Can Trust
http://go.cms.gov/MLNGenInfo

Helpful Contacts

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

Outreach & Education

outreach-education@hp.com

Claims Submissions

DME Jurisdiction A Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
Written Inquiry FAX: 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Overpayments

Refund Checks:
NHIC, Corp.
P.O. Box 809252
Chicago, IL 60680-9252

Payment Offset Fax Requests: 781-741-3916

Note: *Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

Redetermination Request Resulting from an Overpayment:

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Reconsiderations:
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

Faxed Reopenings: 781-741-3914

781-383-4531

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:
NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:
Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

Join the NHIC, Corp. DME MAC A ListServe!

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

What's New

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

DME MAC Jurisdiction A Resource

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

September 2014
Number 33

Publication Information

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

Visit the following websites for more information:

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

TriCenturion: **http://www.tricenturion.com**

CMS: **http://www.cms.gov**

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

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

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

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
Hingham, MA 02043

DME MAC Jurisdiction A offers our quarterly bulletin, the *DME MAC Jurisdiction A Resource*, in electronic format via our Web site, where copies can be printed *free of charge*. To access the bulletin, go to the "Publications" section of our Web site at: **http://www.medicarenhic.com/dme/pubdownload.aspx**. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServe, our electronic mailing lists by visiting: **http://www.medicarenhic.com/dme/listserve.html**

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is $65.00 for hardcopy and $172.00 for CD-ROM. *This subscription includes the four quarterly bulletins published during the calendar year of 2015 - March, June, September and December.* Complete this form and submit with payment, via check only, to the address listed below.

* The CD-ROM version of the bulletin is a Portable Document Format (PDF) file. To view PDFs, you must have Adobe® Acrobat® Reader® installed on your computer.

Name: _____ NPI #: _____

Mailing Address: _____ City: _____

Phone Number: _____ State: _____ Zip: _____

Reason for requesting a hardcopy of the *Resource:* _____

I wish to receive: Hardcopy - $65 per year ☐ CD-ROM - $172 per year ☐

By completing this form and signing below, I certify I do not have access to the Internet, or have some other technical barrier, preventing me from accessing the *DME MAC Jurisdiction A Resource* and therefore request I receive an annual hardcopy subscription. I understand I will have to renew my subscription annually to continue receiving hardcopy of *DME MAC Jurisdiction A Resource*.

Enclose your check payable to: **NHIC, Corp.**

Mail your completed form with payment to:
NHIC, Corp.
Cash Accounting / DME Subscription
75 Sgt William B Terry Drive
Hingham, MA 02043

Signature: _____ Date: _____