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

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ICD-10

General Information

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

Table of Contents

Medical Review

Table of Contents

Outreach & Education

Table of Contents

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

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, 2014
Implementation Date: N/A

Note: *This article was revised on October 30, 2015, to add language to Table A on page 3 regarding Inpatient Psychiatric Facilities (IPFs) and Long Term Care Hospital (LTCH) PPS. All other information remains the same.*

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.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that Span the ICD-10 Implementation Date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 - October 14, 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 (including TEFRA hospitals, Inpatient Prospective Payment System (PPS) hospitals and 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
11X	Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) PPS	*NOTE: If the hospital claim has a discharge and/or through date on or after 10/1/15, and a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10. If a benefits exhaust occurrence code with a September 2015 date exists, the provider must split bill the claim using the benefits exhaust occurrence code date as the through date on the first claim and bill with ICD-9 codes. The subsequent claim is billed as a no pay claim with appropriate ICD-10 coding.	*See Note
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

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, 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 date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 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 anICD-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

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
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 later.	FROM
77X	Federally Qualified Health Clinics (*effective 4/4/10*)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 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 service occurs after 10/1/2015).	FROM

Additional Information

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

Document History

- This article was revised on June 27, 2015, to clarify language on page 2 under "Claims that Span the ICD-10 Implementation Date."
- The article was revised on October 30, 2015, to add information in Table A regarding Inpatient Psychiatric Facilities (IPF) and Long Term Care Hospital (LTCH) PPS guidance.

Claims Submission Alternatives for Providers Who Have Difficulties Submitting ICD-10 Claims (SE1522) (GEN)

MLN Matters® Number: SE1522
Related CR Release Date: N/A
Related CR Transmittal #: N/A
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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 offers physicians, providers, and suppliers information that will assist them in avoiding claims processing disruptions after implementation of International Classification of Diseases, Tenth Edition (ICD-10) on October 1, 2015. It provides information for providers who have difficulties submitting ICD-10 claims due to being unable to complete necessary systems changes or having issues with billing software, vendor(s), or clearinghouse(s).

Background

For FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/
THROUGH dates (on institutional claims) on or after October 1, 2015, entities covered under the *Health Insurance Portability and Accountability Act* (HIPAA) **are required to use ICD-10 code sets** adopted under HIPAA.

ICD-10 Claims Submission Alternatives

If you have difficulties submitting ICD-10 claims due to being unable to complete the necessary systems changes or having issues with your billing software, vendor(s), or clearinghouse(s), the following claims submission alternatives are available:

- Free billing software;
- Provider internet portals;
- Direct Data Entry (DDE); and
- Paper claims.

Each claims submission alternative is discussed in more detail below.

Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015.

FREE BILLING SOFTWARE

Providers Who Submit Claims to MACs

You may download the free billing software that the Centers for Medicare & Medicaid Services (CMS) A/B MACs offer on their web pages. The software has been updated to support ICD-10 codes and requires either a Network Service Vendor (NSV) or dial-up or both to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV or dial-up. The MAC web pages also provide information about NSVs.

This billing software only works for submitting Fee-For-Service (FFS) claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled "*Contractors' ICD-10 Claims Submission Alternatives Web Pages*" (https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf) on the CMS website.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.

Providers Who Submit Claims to DME MACs

DME suppliers may download the free billing software that CMS offers via the Common Electronic Data Interchange (CEDI) website (http://www.ngscedi.com/). The software has been updated to support ICD-10 codes and requires NSV connectivity to transmit Medicare DME claims to CEDI. The software download is free, but there may be fees associated with submitting claims through an NSV. The list of approved NSVs and an NSV Frequently Asked Questions document is available at http://www.ngscedi.com/nsv on the CEDI website. You must also have a CEDI Trading Partner/Submitter ID to use the free billing software to submit claims to CEDI.

- If you currently do not have a CEDI Trading Partner ID (begins with A08, B08, C08, or D08) to submit claims directly to CEDI (for example, you submit claims through a clearinghouse or billing service), you will need to complete the necessary CEDI enrollment forms to obtain a CEDI Trading Partner ID.
- If you currently have a CEDI Trading Partner ID, you will use that to submit claims with the free billing software.

You can find CEDI enrollment forms at http://www.ngscedi.com/forms/formsindex.htm on the CEDI website. You should submit the forms to CEDI as soon as possible, but no later than September 15, 2015, to allow CEDI time to process your request and for any testing you might want to do prior to the October 1, 2015, ICD-10 implementation. You will also need to allow for any additional time to sign up and establish connectivity to CEDI through the NSV that you choose.

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.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled "*Contractors' ICD-10 Claims Submission Alternatives Web Pages*" (https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf) on the CMS website.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected by Medicare.

PROVIDER INTERNET PORTALS

In some cases, you may be able to use your MAC's provider internet portal to submit ICD-10 compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission. Provider portal internet claim submission is not available for institutional or supplier claims.

Information about registering for access to provider internet portals is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled "*Contractors' ICD-10 Claims Submission Alternatives Web Pages*" (https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf) on the CMS website.

Please note that claims submitted via our provider portal must contain ICD-10 codes for FROM dates of service on or after October 1, 2015. Those submitted containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected through normal claims editing processes. ICD-9 codes will still be accepted for FROM dates prior to October 1, 2015.

DDE

Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. DDE requires a connectivity service provided by an external company to establish the connection.

Information about registering to submit claims via DDE and lists of DDE service vendors is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled "*Contractors' ICD-10 Claims Submission Alternatives Web Pages*" (https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf) on the CMS website.

Please note that claims submitted via DDE must contain ICD-10 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015, will be Returned to Provider (RTP).

PAPER CLAIMS

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html on the CMS website. Please note that to submit paper claims, you must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

Information about submitting paper claims and ordering claim forms is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled "*Contractors' ICD-10 Claims Submission Alternatives Web Pages*" (https://www.cms.gov/Medicare/Coding/ICD10/Downloads/Contractors-ICD-10-Claims-Submission-Alternatives-Web-Pages.pdf) on the CMS website.

Waivers Subject to MAC Evaluation

Providers must apply for and **meet all** of the following requirements to qualify for a waiver of the ASCA provisions:

- Your software vendor is not ICD-10 ready, and it will cause a financial hardship for you to switch to another vendor; **or**
- Your software is not ICD-10 ready, and it will cause a financial hardship for you to switch to new software; **and**
- Your MAC's provider internet portal does not support electronic claims submissions; **and**
- It would cause financial hardship for you to procure the services of a billing agent/clearinghouse.

It is the provider's responsibility to submit all of the following documentation to the MAC to establish the validity of a waiver request:

- A letter from the vendor stating that their software is not ICD-10 compliant; **or**
- Attestation from the provider stating that your software is not ready for ICD-10; **and**
- Attestation of provider financial hardship; **and**
- Acknowledgement that paper claims must be submitted in a machine scannable format.

If the MAC determines that the waiver request meets the criteria described above and proper documentation has been provided, the MAC will grant the waiver request.

Corrective Action Plan (CAP)

A provider who qualifies for a waiver to submit paper claims will be placed on a CAP not to exceed 120 days and must submit a CAP detailing the steps, with associated timelines, being taken to become ICD-10 compliant.

Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.

Information and Resources

Visit the following web pages to find information and resources that will assist you in submitting ICD-10 codes to Medicare:

- General ICD-10-CM/PCS information: http://www.cms.gov/Medicare/Coding/ICD10/index.html;
- ICD-10 Fee-For-Service provider resources including claims processing and billing, coding, unspecified ICD-10-CM codes, home health provider information, NCDs and LCDs, testing and results, features and benefits, and calls and background: https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html;
- General Equivalence Mappings: http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html; and
- ICD-10 National Coverage Determinations: http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html on the CMS website.

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

Implementation of ICD-10-CM/PCS (GEN)

Dear Physician,

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all *Health Insurance Portability and Accountability Act*-covered entities, which includes suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Physicians are strongly encouraged to engage in an open dialogue with their DMEPOS suppliers to verify the DMEPOS item(s) they are ordering are properly supported by the ICD-10 diagnosis code(s) documented within the medical records. This will ensure your Medicare patients receive the DMEPOS items they need and facilitate DMEPOS supplier claims payment.

Although the Centers for Medicare and Medicaid Services (CMS) has allowed for some additional flexibility in regards to claims auditing for physician services for the first 12 months following implementation, certain DMEPOS policies, especially those based on Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) require ICD-10 guidelines be followed for dates of service on and after October 1, 2015 for appropriate processing and claim reimbursement. This means that for certain DMEPOS items ordered for Medicare beneficiaries, only designated ICD-10 diagnosis codes will be allowable within the claims processing system for proper reimbursement. Not only must the appropriate ICD-10 diagnosis code, with the maximum level of specificity, be provided to the DMEPOS supplier for claim submission; that ICD-10 diagnosis code must be supported and documented appropriately within the patient's medical record.

Sincerely,

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2015-2016 Influenza (Flu) Resources for Health Care Professionals (SE1523) (GEN)

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Implementation Date: N/A

Provider Types Affected

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

What You Need to Know

- Keep this Special Edition MLN Matters® article and refer to it throughout the 2015 - 2016 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

Introduction

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

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

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

Know What to Do About the Flu!

Payment Rates for 2015-2016

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the Average Wholesale Price (AWP), except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Effective for services provided on August 1, 2015, through those provided on July 31, 2016, the following Medicare Part B payment allowances for HCPCS and CPT codes apply.

CPT Codes:

CPT Code	Effective Dates	Payment Allowance
90630	8/1/2015 - 7/31/2016	$23.467
90654	8/1/2015 - 7/31/2016	Pending
90655	8/1/2015 - 7/31/2016	Pending
90656	8/1/2015 - 7/31/2016	$13.880
90657	8/1/2015 - 7/31/2016	$6.022
90661	8/1/2015 - 7/31/2016	$22.288
90662	8/1/2015 - 7/31/2016	$36.315
90672	8/1/2015 - 7/31/2016	Pending
90673	9/26/2015 - 7/31/2016	$37.193

CPT Code	Effective Dates	Payment Allowance
90685	8/1/2015 - 7/31/2016	$24.596
90686	8/1/2015 - 7/31/2016	$18.155
90687	8/1/2015 - 7/31/2016	$9.134
90688	8/1/2015 - 7/31/2016	$18.269

HCPCS Codes:

HCPCS Code	Effective Dates	Payment Allowance
Q2035	8/1/2015 - 7/31/2016	$13.025
Q2036	8/1/2015 - 7/31/2016	Pending
Q2037	8/1/2015 - 7/31/2016	$15.830
Q2038	8/1/2015 - 7/31/2016	$12.044
Q2039	8/1/2015 - 7/31/2016	Flu Vaccine Adult - Not Otherwise Classified: Payment allowance is to be determined by the local claims processing contractor.

The above pricing, and any required updates, will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html on the CMS website.

Educational Products for Health Care Professionals

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

1. **MLN Influenza Related Products for Health Care Professionals**
   - **Medicare Part B Immunization Billing chart**
     http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf
   - **Preventive Services chart**
     http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
   - **MLN Preventive Services Educational Products web page**
     http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html
   - **Preventive Services Educational Products PDF**
     http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf

2. **Other CMS Resources**
   - **Immunizations web page**
     http://www.cms.gov/Medicare/Prevention/Immunizations/index.html
   - **Prevention General Information**
     http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html
   - **CMS Frequently Asked Questions**
     http://questions.cms.gov/faq.php
   - **Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 - Immunizations**
     http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
   - **Medicare Claims Processing Manual - Chapter 18, Preventive and Screening Services**
     http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf

3. Other Resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2015 - 2016 flu season:

- **Advisory Committee on Immunization Practices**
  http://www.cdc.gov/vaccines/acip/index.html
- Other sites with helpful information include:
  - **Centers for Disease Control and Prevention** - http://www.cdc.gov/flu;
  - **Flu.gov** - http://www.flu.gov;
  - **Food and Drug Administration** - http://www.fda.gov;
  - **Immunization Action Coalition** - http://www.immunize.org;
  - **Indian Health Services** - http://www.ihs.gov;
  - **National Alliance for Hispanic Health** - http://www.hispanichealth.org;
  - **National Foundation For Infectious Diseases** - http://www.nfid.org/influenza;
  - **National Library of Medicine and NIH Medline Plus** - http://www.nlm.nih.gov/medlineplus/immunization.html
  - **National Network for Immunization Information** - http://www.immunizationinfo.org;
  - **National Vaccine Program** - http://www.hhs.gov/nvpo;
  - **Office of Disease Prevention and Health Promotion**
    http://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services;
  - **Partnership for Prevention** - http://www.prevent.org; and
  - **World Health Organization** - http://www.who.int/en

Beneficiary Information

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

2016 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update (MM9340) (GEN)

MLN Matters® Number: MM9340
Related CR Release Date: September 11, 2015
Related CR Transmittal #: R3349CP

Related Change Request (CR) #: CR 9340
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

Impact to You

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 9340 could impact your payments.

What You Need to Know

CR 9340 provides the 2016 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2015, the new code files for Part B processing, and the new Excel and PDF files for Part A processing will be available at http://www.cms.gov/SNFConsolidatedBilling on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2016.

What You Need to Do

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

Background

The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

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

Additional Information

The official instruction, CR 9340 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3349CP.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.

2016 Update to the Amount in Controversy (GEN)

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2015 is $150. This amount will remain at $150 for ALJ hearing requests filed on or after January 1, 2016. The amount that must remain in controversy for review in Federal District Court requested on or before December 31, 2015 is $1,460. This amount will increase to $1,500 for appeals to Federal District Court filed on or after January 1, 2016.

Join the NHIC, Corp. DME MAC JA ListServe!

Visit http://www.medicarenhic.com/dme/listserve.html today!

Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM9431) (GEN)

MLN Matters® Number: MM9431
Related CR Release Date: November 23, 2015
Related CR Transmittal #: R3416CP

Related Change Request (CR) #: CR 9431
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9431 provides the CY 2016 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the "*Medicare Claims Processing Manual*," Chapter 23, Section 60 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf).

Payment on a fee schedule basis is required by the *Social Security Act* (the Act) for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from the National Competitive Bidding Program (CBP). The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP.

CMS issued a final rule on November 6, 2014 (79 FR 66223) on the methodologies for adjusting DMEPOS fee schedule amounts using information from competitive bidding programs. Program instructions on these changes are also available in Transmittal 3350, CR 9239 on September 11, 2015. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home).

There are three general methodologies used in adjusting the fee schedule amounts:

1. Adjusted Fee Schedule Amounts for Areas within the Contiguous United States

The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 CBAs).

Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

2. Adjusted Fee Schedule Amounts for Areas outside the Contiguous United States
Areas outside the contiguous United States (i.e., noncontiguous areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. Adjusted Fee Schedule Amounts for Items Included in 10 or Fewer Areas
DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the straight average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas (i.e., non-contiguous and contiguous).

Phasing In Fee Schedule Amounts
The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the July quarterly update files will include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts.

Fee schedule amounts that are adjusted using SPAs will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where the SPAs from CBPs no longer in effect are used to adjust fee schedule amounts (§414.210(g)(4)), the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year (such as 2017 or 2018) claims with dates of service on or after July 1, 2016, the fee schedule amount on the DMEPOS file is based on 100 percent of the adjusted fee schedule amount.

Fee Schedule and Rural ZIP Code Files
The DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments taking effect January 1, 2016. In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file has been updated to include rural payment amounts for those HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology will remain unchanged. The DMEPOS and PEN fee schedules and the Rural ZIP code file Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties after October 29, 2015 at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched on the CMS website.

New Codes Added Effective January 1, 2016:
The HCPCS codes A4337, E1012, E0465, E0466, and L8607 are being added to the HCPCS effective January 1, 2016. Codes E1012, E0465, E0466, and L8607 will be added to the DMEPOS fee schedule file effective January 1, 2016.

Codes Deleted
The following codes will be deleted from the DMEPOS fee schedule files effective January 1, 2016: E0450, E0460, E0461, E0463, and E0464.

Shoe Modification Codes
Effective January 1, 2016, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2016. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2016, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during CY 2014.

Update to CR8566 - Wheelchair Accessory

Also as part of CR9431, CMS is adding HCPCS code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type). Code E1012 is eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016.

The 2015 Deflation Factors for Gap-Filling Purposes

For gap-filling pricing purposes, the 2015 deflation factors by payment category are: 0.459 for Oxygen, 0.462 for Capped Rental, 0.463 for Prosthetics and Orthotics, 0.588 for Surgical Dressings, 0.639 for Parental and Enteral Nutrition, 0.978 for Splints and Casts and 0.962 for Intraocular Lenses.

Ventilators

Fee schedules are being added for the following ventilator HCPCS codes:

- E0465 Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube); and
- Code E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell).

Code E0465 is added to the HCPCS for billing Medicare claims previously submitted under E0450 and E0463. Code E0466 is added to the HCPCS for billing Medicare claims previously submitted under E0460, E0461 and E0464. The fee schedule amounts for codes E0465 and E0466 are established using the Medicare fee schedule amounts for HCPCS code E0450, based on updated average reasonable charges for ventilators from July 1, 1986, through June 30, 1987.

Diabetic Testing Supplies (DTS)

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

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. The CBP for mail order diabetic supplies is effective July 1, 2013 to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, CR 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013.
(See related MLN Matters Articles MM8325
(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8325.pdf)
and MM8204
(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8204.pdf).)

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data only for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts will be updated annually by the covered item update factor adjusted for multi-factor productivity. The mail order DTS fee schedule amounts are not used in determining the Medicare allowed payment amounts for mail order DTS. The single payment amount Public Use File (PUF) for the national mail order CBP is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with The Act, the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the single payment amounts established under the national mail order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which are based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order single payment amounts, will be provided on the DMEPOS fee schedule file in the Hawaii column of the mail order (KL) DTS (A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259) codes for dates of service January 1, 2016, through June 30, 2016. Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. The Northern Mariana Island DTS mail order payment amounts will no longer appear in the Hawaii column and the DTS mail order (KL) fee schedules for all states and territories will be removed from the DMEPOS fee schedule file as of July 1, 2016.

2016 Fee Schedule Update Factor of -0.4 Percent

For CY 2016, an update factor of 0.1 percent is applied to certain DMEPOS fee schedule amounts. For the majority of fee schedule amounts, in accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2016 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2015, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi[AG5] -Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 0.1 percent. Thus, the 0.1 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net decrease of -0.4 percent for the update factor.

2016 Update Labor Payment Rates for HCPCS Codes K0739, L4205 and L7520 January 1, 2016 through December 31, 2016

The 2016 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2016, through December 31, 2016. Those amounts are as follows:

STATE	K0739	L4205	L7520
AK	$28.01	$31.91	$37.54
AL	$14.87	$22.16	$30.08
AR	$14.87	$22.16	$30.08
AZ	$18.39	$22.13	$37.01
CA	$22.81	$36.38	$42.39
CO	$14.87	$22.16	$30.08
CT	$24.83	$22.65	$30.08
DC	$14.87	$22.13	$30.08
DE	$27.38	$22.13	$30.08
FL	$14.87	$22.16	$30.08
GA	$14.87	$22.16	$30.08
HI	$18.39	$31.91	$37.54
IA	$14.87	$22.13	$36.01
ID	$14.87	$22.13	$30.08
IL	$14.87	$22.13	$30.08
IN	$14.87	$22.13	$30.08
KS	$14.87	$22.13	$37.54
KY	$14.87	$28.37	$38.47
LA	$14.87	$22.16	$30.08
MA	$24.83	$22.13	$30.08
MD	$14.87	$22.13	$30.08
ME	$24.83	$22.13	$30.08
MI	$14.87	$22.13	$30.08
MN	$14.87	$22.13	$30.08
MO	$14.87	$22.13	$30.08
MS	$14.87	$22.16	$30.08
MT	$14.87	$22.13	$37.54

STATE	K0739	L4205	L7520
NC	$14.87	$22.16	$30.08
ND	$18.53	$31.84	$37.54
NE	$14.87	$22.13	$41.94
NH	$15.97	$22.13	$30.08
NJ	$20.06	$22.13	$30.08
NM	$14.87	$22.16	$30.08
NV	$23.69	$22.13	$41.00
NY	$27.38	$22.16	$30.08
OH	$14.87	$22.13	$30.08
OK	$14.87	$22.16	$30.08
OR	$14.87	$22.13	$43.25
PA	$15.97	$22.79	$30.08
PR	$14.87	$22.16	$30.08
RI	$17.72	$22.81	$30.08
SC	$14.87	$22.16	$30.08
SD	$16.62	$22.13	$40.22
TN	$14.87	$22.16	$30.08
TX	$14.87	$22.16	$30.08
UT	$14.91	$22.13	$46.84
VA	$14.87	$22.13	$30.08
VI	$14.87	$22.16	$30.08
VT	$15.97	$22.13	$30.08
WA	$23.69	$32.47	$38.57
WI	$14.87	$22.13	$30.08
WV	$14.87	$22.13	$30.08
WY	$20.73	$29.53	$41.94

2016 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

CMS is implementing the 2016 national monthly fee schedule payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2016, through June 2016. The updated national 2016 monthly payment amount of $180.10 for the stationary oxygen equipment codes will not appear on the 2016 DMEPOS fee schedule. Instead, for dates of service January 1, 2016, through June 30, 2016, the 2016 fee schedule rate of $180.10 blends with the stationary oxygen regional SPAs based on 50 percent of the un-adjusted stationary oxygen fee schedule amounts and 50 percent of the adjusted oxygen regional SPAs.

Beginning July 1, 2016, the stationary oxygen equipment fee schedule amounts on the quarterly update to the CY 2016 DMEPOS fee schedule file will reflect 100 percent of the adjusted oxygen regional SPAs.

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

2016 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2016 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, Change Request (CR) 6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. (See related MLN Matters Articles MM6792 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6792.pdf) and MM6990 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6990.pdf).) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2016 maintenance and servicing fee is adjusted by the -0.4 percent MFP-adjusted covered item update factor to yield a CY 2016 maintenance and servicing fee of $69.48 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR9431, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3416CP.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.

Claim Status Category and Claim Status Code Update (MM9427) (GEN)

MLN Matters® Number: MM9427
Related CR Release Date: November 20, 2015
Related CR Transmittal #: R3413CP

Related Change Request (CR) #: CR 9427
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9427 informs MACs about the changes to Claim Status Category and Claim Status Codes.

Background

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee (NCMC) in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s).

Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The NCMC meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC has decided to allow the industry 6 months for implementation of newly added or changed codes.

The code 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 January 2016 committee meeting shall be posted on these sites on or about February 1, 2016. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes, by the implementation date of CR9427.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9427.

CMS and the MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses and when sending ASC X12 277 Healthcare Claim Acknowledgments. References in this CR to "277 responses" and "claim status responses" encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information

The official instruction, CR9427, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3413CP.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.

Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM) (MM8984) (GEN)

MLN Matters® Number: MM8984
Related CR Release Date: September 18, 2015
Related CR Transmittal #: R114MSP and R3358CP

Related Change Request (CR) #: CR 8984
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8984, through which the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claims processing requirements specific to Ongoing Responsibility for Medicals (ORM) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation in Medicare Secondary Payer (MSP) situations.

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans are required to report settlements, judgments, awards, or other payments to CMS, including ORM. The purpose of CR 8984 is to educate and instruct providers and the MACs about the policy and procedures related to ORM reporting. Make sure that your billing staffs are aware of these changes.

NOTE: *MSP claims impacted by employer Group Health Plan coverage will be not affected by this change.*

Background

Pursuant to section 1862(b)(8) of the *Social Security Act*, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to CMS. The applicable plan is the "Responsible Reporting Entity" (RRE) for this process. The required reporting includes instances where the RRE has ORM associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date, and this information is uploaded to Medicare's Common Working File (CWF) by the Benefit Coordination & Recovery Center (BCRC).

NOTE: *An ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.*

Pursuant to section 1862(b)(2)(A)(ii) of the *Social Security Act* (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

CR 8984 includes modifications to Medicare systems to automate the fact that ORM responsibility is assumed, exists, or did exist for a particular period of time. All MACs shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSPD (No-Fault - 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. When claims are processed, Medicare will compare the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record. All MACs shall deny claims where the ORM indicator is present for the period covered by the claim **and** the diagnosis code(s) match(es) (or match(ed)) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed. (Any claim will also process for a potential Workers' Compensation Medicare Set-Aside (WCMSA) denial where there is no denial based upon the ORM indicator.)

As stated above, MACs shall deny payment for claim lines with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement; therefore, a conditional payment cannot be made to providers when ORM exists for the item or service in question. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been appropriately exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

When Medicare denies claims due to the ORM indicator, the remittance advice for the denied claim will reflect one of the following Claims Adjustment Reason Codes (CARC) and Remittance Advice Remarks Codes (RARC):

- CARC 19 - "This is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier." Also, RARC N728 - "A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" - will appear. (**NOTE:** *To be used with Group Code PR.*)

- CARC 20 - "This injury/illness is covered by the liability carrier." Also, RARC N725 - "A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" - will appear. (**NOTE:** *To be used with Group Code PR.*)

- CARC 21 - "This injury/illness is the liability of the no-fault carrier." Also, RARC N727 - "A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" - will appear. (**NOTE:** *To be used with Group Code PR.*)

However, Medicare payment will be made for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; for example, benefits appropriately exhausted, or benefits no longer covered due to state imposed limits, etc.):

- Any of the following CARCs are found on the ORM claim: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 201, 204, 242, 256, B1 (if a Medicare covered visit), B14; and
- The service is covered and otherwise reimbursable by Medicare.

Additional Information

Important: Providers, physicians, and other suppliers should know that CMS is implementing use of the ORM indicator on a gradual basis, beginning in January 2016. Appeal rights apply to all claims denied due to ORM as part of MSP claims processing.

The official instruction, CR 8984, was issued to your MAC regarding this change via two transmittals. The first transmittal is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R114MSP.pdf and the second transmittal is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3358CP.pdf on the CMS website.

You may find further information about the mandatory reporting required by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans by going to http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html 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.

Denial for Power Mobility Device (PMD) Claim from a Supplier of Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) When Ordered By a Non-Authorized Provider (MM8239) (MOB)

MLN Matters® Number: MM8239 Revised
Related CR Release Date: November 6, 2013
Related CR Transmittal #: R1305OTN

Related Change Request (CR) #: CR 8239
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: This article was revised on September 24, 2015, to change the link to the list of providers authorized to order a PMD on page 5. That link was changed to https://data.cms.gov on the CMS website. For a complete list of any other changes to this article, please refer to the Document History Section. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for suppliers of Durable Medical Equipment (DME) who submit claims to DME Medicare Administrative Contractors (DME/MACs) for Power Mobility Devices (PMDs) provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8239 instructs Medicare contractors and system maintainers to implement edits to deny claims for certain PMDs if the ordering/referring provider is not on Medicare's list of providers eligible to order/refer these PMDs.

Make sure that your billing staffs are aware of these requirements and you do not order if you are not an authorized provider. Suppliers are required to ascertain that the provider is authorized to order a PMD. A denial of the claim will be issued if the provider is not of an authorized specialty to order a PMD.

Background

Section 302(a)(2) of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA), added Section 1834(a)(1)(E)(iv) to the Act which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in section 1861(r)(1) of the Act), or a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) (as these terms are defined in Section 1861(aa)(5) of the Act) has conducted a face-to-face examination of the beneficiary and written a prescription for the item. This purpose of CR 8239 is to create an edit to deny any DMEPOS claims where the ordering/prescribing provider is not an eligible *provider (physician, PA, NP, or CNS).*

The following are the policies/definitions that impact Medicare allowances for PMDs:

1. *Social Security Act* Section 1834(a)(1)(E)(iv) standards for power wheelchairs;
   - Effective on the date of the enactment of this subparagraph in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in Section 1861(r)(1)), a PA, NP or CNS (as those terms are defined in Section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

2. *Social Security Act* Section 1861(r)(1)
   - The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)).

3. *Social Security Act* Section 1861(aa)(5)
   - The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a PA or NP who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

   - The term "clinical nurse specialist" means, for purposes of this title, an individual who is a registered nurse and is licensed to practice nursing in the State in which the CNS services are performed; and holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

4. Based on 42 CFR Part 410.38(c), the following definitions apply: PMD means a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

Key Points of CR8239

The list of specified covered, PMD items: HCPCS Code and Description includes the following:

- K0800-K0808 and K0812: ALL POWER OPERATED VEHICLES
- K0813-K0891, K0898: POWER WHEELCHAIRS , and
- K0013: CUSTOM MOTORIZED/ POWER WHEELCHAIR BASE.

The list of authorized physician specialties and their corresponding CMS specialty code in Provider Enrollment, Chain, and Ownership System (PECOS) is as follows:

Medicare PECOS

CODE	APPROVED PHYSICAN SPECIALTIES
01	GENERAL PRACTICE
02	GENERAL SURGERY
03	ALLERGY/IMMUNOLOGY
04	OTOLARYNGOLOGY
05	ANESTHESIOLOGY
06	CARDIOVASCULAR DISEASE (CARDIOLOGY)
07	DERMATOLOGY
08	FAMILY PRACTICE

CODE	APPROVED PHYSICAN SPECIALTIES
09	INTERVENTIONAL PAIN MANAGEMENT
10	GASTROENTEROLOGY
11	INTERNAL MEDICINE
12	OSTEOPATHIC MANUPULATIVE MEDICINE
13	NEUROLOGY
14	NEUROSURGERY
16	OBSTETRICS/GYNECOLOGY
17	HOSPICE/PALLIATIVE CARE
18	OPHTHALMOLOGY
20	ORTHOPEDIC SURGERY
21	CARDIAC ELECTROPHYSIOLOGY
22	PATHOLOGY
23	SPORTS MEDICINE
24	PLASTIC AND RECONSTRUCTIVE SURGERY
25	PHYSICAL MEDICINE AND REHABILITATION
26	PSYCHIATRY
27	GERIATRIC PSYCHIATRY
28	COLORECTAL SURGERY (PROCTOLOGY)
29	PULMONARY DISEASE
30	DIAGNOSTIC RADIOLOGY
33	THORACIC SURGERY
34	UROLOGY
36	NUCLEAR MEDICINE
37	PEDIATRIC MEDICINE
38	GERIATRIC MEDICINE
39	NEPHROLOGY
40	HAND SURGERY
44	INFECTIOUS DISEASE
46	ENDOCRINOLOGY
66	RHEUMATOLOGY
72	PAIN MANAGEMENT
76	PERIPHERAL VASCULAR DISEASE
77	VASCULAR SURGERY
78	CARDIAC SURGERY
79	ADDICTION MEDICINE
81	CRITICAL CARE (INTENSIVISTS)
82	HEMATOLOGY
83	HEMATOLOGY/ONCOLOGY
84	PREVENTATIVE MEDICINE
85	MAXILLOFACIAL SURGERY
86	NEUROPSYCHIATRY
90	MEDICAL ONCOLOGY
91	SURGICAL ONCOLOGY
92	RADIATION ONCOLOGY
93	EMERGENCY MEDICINE
94	INTERVENTIONAL RADIOLOGY
98	GYNECOLOGICAL ONCOLOGY
C0	SLEEP LABORATORY/MEDICINE

The list of authorized non-physician specialties and their corresponding CMS specialty code in PECOS is as follows:

CODE	APPROVED NON-PHYSICIAN SPECIALTY
50	NURSE PRACTITIONER
89	CLINICAL NURSE SPECIALIST
97	PHYSICIAN ASSISTANT

Suppliers are required to ascertain that the provider is authorized to order a PMD. A list of providers authorized to order a PMD can be accessed (beginning April 2014) at https://data.cms.gov on the CMS website.

A denial of the claim will be issued if the provider is not on the PECOS list. Be aware that all of the criteria for coverage of PMDs must be met.

When a claim for a relevant PMD is denied because the ordering/referring provider was ineligible to place the order, Medicare will use the a Claim Adjustment Reason Code of 183 (The Referring Provider is not eligible to refer the service billed) and a Remittance Advice Remarks Code of N574 (Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer).

Additional Information

The official instruction, CR 8239, issued to your DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1305OTN.pdf on the CMS website.

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

For a look at face-to-face requirements and a checklist you may review SE1112, "*Power Mobility Device Face-to-Face Examination Checklist*" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1112.pdf on the CMS website.

Document History

Date	Description
September 24, 2015	This article was revised to change the link to a list of providers authorized to order a PMD on page 5. That link was changed to https://data.cms.gov on the CMS website.

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, NHIC forms submission and status, as well as print Remittances over the internet. The PSP also includes an Additional Documentation Request (ADR) Inbox and a MR Service Center that enables you to respond to ADR requests electronically. The PSP is currently available for open enrollment. There is no charge to participate!

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

MLN Matters® Number: SE1305 Revised
Related CR Release Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN

Related Change Request (CR) #: 6421, 6417, 6696, 6856
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on October 21, 2015, to add a statement on page 8, item c. regarding a legislative change impacting the two year opt-out period. All other information remains the same.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

Provider Action Needed

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

What Providers Need to Know

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

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

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

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. **When submitting the CMS-1500 or the CMS-1450, please only include the first and last name**

as it appears on the ordering and referring file found on https://data.cms.gov **on the CMS website.** *Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.*

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

Background

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

Below are examples of some of these types of claims:

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

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

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
- Physician Assistants,
- Clinical Nurse Specialists,
- Nurse Practitioners,
- Clinical Psychologists,
- Interns, Residents, and Fellows,
- Certified Nurse Midwives, and
- Clinical Social Workers.

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

CMS would like to highlight the following limitations:

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

Questions and Answers Relating to the Edits

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

2. Why did Medicare implement these edits?
These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?
These edits were implemented in two phases:

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

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

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

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

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

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

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

N272 Missing/incomplete/invalid other payer attending provider identifier

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

CMS has taken actions to reduce the number of informational messages. In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs (*NPIs were added only when the matching criteria verified the NPI.*). On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to https://data.cms.gov on the CMS website.

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

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

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

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

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

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

37236 - This reason code will assign when:

- The statement "From" date on the claim is on or after the date the phase 2 edits are turned on
- The type of bill is '32' or '33'
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code

37237 - This reason code will assign when:

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

Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?
In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you, the ordering/referring provider, need to ensure that:**

a. You have a current Medicare enrollment record.

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

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

- You need to submit **either an electronic application through the use of internet-based PECOS or a paper enrollment application** to Medicare.
  - i. **For paper applications** - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - ii. **For electronic applications** - complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
  - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
  - iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html, click on "Internet-based PECOS" on the left-hand

side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html).

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

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit). Note, however, that prior to enactment of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), physician/practitioner opt-out affidavits were only effective for 2 years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every 2 years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare Administrative Contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

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

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

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

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

f. Make sure your claims are properly completed.

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

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

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

g. What if my claim is denied inappropriately?
If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

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

i. Are the Phase 2 edits based on date of service or date of claim receipt?
The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?
Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional Guidance

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

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

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

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

Additional Information

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

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

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

Additional Article Updates

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

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

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

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

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

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

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

Important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available in MLN Matters® Article SE1311at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1311.pdf on the CMS website.

Document History

Date	Description
October 21, 2015	The article was revised to add a statement on page 8, item c. regarding the impact of recent legislation on the two year opt-out period.
September 24, 2015	This article was revised to change the link to the "Ordering Referring Report" page. That link was changed to https://data.cms.gov on the CMS website.
January 26, 2015	This article was revised to include a link to article SE1311, which includes important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries.
April 19, 2013	This article was previously revised add references to the CMS-1450 form and to add question H. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website.

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 (MM9350) (GEN)

MLN Matters® Number: MM9350
Related CR Release Date: November 20, 2015
Related CR Transmittal #: R3411CP

Related Change Request (CR) #: CR 9350
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9350 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on 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 publication. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2016.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Patient Protection and *Affordable Care Act of 2010*.

The *Health Insurance Portability and Accountability Act* (HIPAA) amended the *Social Security Act* (the Act) by adding Part C - Administrative Simplification - to Title XI, requiring that the Secretary of HHS (the Secretary) 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.

CR9350 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2016. This update is based on the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2015.

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.

Additional Information

The official instruction, CR9350, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3411CP.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.

Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP) (MM9239) (GEN)

MLN Matters® Number: MM9239
Related CR Release Date: September 11, 2015
Related CR Transmittal #: R3350CP
Related Change Request (CR) #: CR 9239
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

Impact to You

The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the DMEPOS fee schedule files beginning January 1, 2016.

What You Need to Know

Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the Competitive Bidding Program (CBP). Section 1842(s)(3(B) of the *Social Security Act* (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. Change Request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP.

What You Need to Do

Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.

Background

Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the Round 1 Rebid contracts beginning January 1, 2011, in 9 competitive bid areas (CBAs). Contracts for the Round 1 Rebid expired on December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts for the DMEPOS CBP at least once every 3 years. The same 9 CBAs were rebid under the Round 1 Recompete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the Round 2 contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the Round 2 Recompete scheduled to take effect on July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the total number of CBAs.

The product categories and HCPCS codes included in each Round of the CBP are available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Competitive Bidding Implementation Contractor (CBIC) website.

Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. Section 1842(s)(3(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at 42 Code of Federal Regulations (CFR) 414.210(g). There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and
- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee Schedule Amounts for Areas within the Contiguous United States

This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP Code where at least 50 percent of the total geographical area of the ZIP Code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee Schedule Amounts for Areas outside the Contiguous United States

Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

Fee Schedule Amounts for Items Included in 10 or Fewer CBAs

DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).

Phasing In and Updating Fee Schedule Amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016 through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that

would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made (for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in Chapter 23 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), Section 60.1 of the "*Medicare Claims Processing Manual*." Similarly, the Fiscal Intermediary (FI) DMEPOS fee schedule file format, outlined in Chapter 23 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), Section 50.2 of the "*Medicare Claims Processing Manual*," will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments. The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in Chapter 23, Section 70.1 of the "*Medicare Claims Processing Manual*."

Additional Information

The official instruction, CR 9239 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3350CP.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.

January 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9351) (DRU)

MLN Matters® Number: MM9351 Revised
Related CR Release Date: September 18, 2015
Related CR Transmittal #: R3354CP

Related Change Request (CR) #: CR 9351
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Note: *This article was revised on September 23, 2015, to correct the title of the article. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

Medicare will use the January 2016 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2016, with dates of services from January 1, 2016, through March 31, 2016.

Change Request (CR) 9351, from which this article is taken, instructs MACs to implement the January 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised October 2015, July 2015, and April 2015, and January 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply 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 *Medicare Claims Processing Manual*, Chapter 4, Section 50, Outpatient Code Editor (OCE).

The following table shows how the files will be applied.

Files	Effective for Dates of Service
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015

Additional Information

The official instruction, CR 9351, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3354CP.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 Remit Easy Print (MREP) Upgrade (MM9291) (GEN)

MLN Matters® Number: MM9291
Related Transmittal #: R1552OTN
Implementation Date: April 4, 2016

Related CR Release Date: November 5, 2015
Change Request (CR) #: CR 9291
Effective Date: April 1, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9291 contains upgrades to Medicare Remit Easy Print (MREP) software based on enhancement requests received through the Medicare Administrative Contractors (MACs) and/or the Centers for Medicare & Medicaid Services (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

MREP software was developed by 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.

CMS offers free software - MREP - to view and print *Health Insurance Portability and Accountability Act* (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/suppliers to help them transition to ERA.

A key change in this version of the MREP application is an upgrade so that when a user prints the Claim Detail with the Glossary option selected, the Glossary will begin on the same page of the last claim if there are available print lines on the page, rather than always printing on a new page.

Another upgrade to the MREP application is that the Claim Adjustment Reason Code (CARC) is added as a new criteria option for the existing search functionality. The search scope will be limited to a single selected remit, as it is today.

Additional Information

The official instruction, CR9291, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1552OTN.pdf on the CMS website.

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

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2016 (MM9383) (GEN)

MLN Matters® Number: MM9383
Related CR Release Date: October 16, 2015
Related CR Transmittal #: R3377CP
Related Change Request (CR) #: CR 9383
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9383 to provide the DMEPOS Competitive Bidding Program (CBP) January 2016 quarterly update. CR9383 provides specific instructions for the DME MACs in implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

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

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

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

Additional Information

The official instruction, CR9383, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3377CP.pdf on the CMS website.

More information is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Home on the Internet. This site includes information on all rounds of the CBP, including product categories single payment amounts for the Round 1 Recompete, Round 2, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.

There are a number of products in the *MLN Catalog of Products* (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNCatalog.pdf) that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.

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

Remittance Advice Remark and Claim Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM9374) (GEN)

MLN Matters® Number: MM9374
Related CR Release Date: November 25, 2015
Related CR Transmittal #: R3418CP
Related Change Request (CR) #: CR 9374
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

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) 9374 updates 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 software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it.

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 CARCs and RARCs, as appropriate, 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.

The Centers for Medicare & Medicaid Services (CMS) instructs the MACs to conduct updates based on the code update schedule that results in publication three times a year - around March 1, July 1, and November 1.

CR9374 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have 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. MACs make necessary program changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per CR9374 or as posted on the WPC website when:

- Medicare is not primary;
- The COB claim is received after the deactivation effective date; and

- The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC website.

MACs make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare Secondary Payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after the deactivation date.

SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC website, found at http://wpc-edi.com/Reference/ on the Internet. If any new or modified code has an effective date past the implementation date specified in CR9374, 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 per year and may not match the CMS systems release schedule. For this recurring CR, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR9278, with a related MLN Matters® article available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9278.pdf on the CMS website.)

In accordance with HIPAA Legislation Published in the Federal Register (45 CFR Part 162), covered entities are required to comply with established standards and code set regulations. Furthermore, the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) further defines the requirements for the 835 transaction by specifying Phase III Operating Rules, the 835 transaction (Health Care Claim Payment/Advice) and standard paper remittance advice which require the use of CARCs and RARCs.

Additional Information

The official instruction, CR9374, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3418CP.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.

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

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM9278) (GEN)

MLN Matters® Number: MM9278 Revised
Related Transmittal #: R3298CP
Effective Date: October 1, 2015
Related CR Release Date: August 6, 2015
Change Request (CR) #: CR 9278
Implementation Date: October 5, 2015

Note: *This article was revised on October 13, 2015, to correct a code in the Modified Codes - RARC table on pages 3-4. The code of N109 is now shown in that table, instead of the incorrect code of M109. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

What You Need to Know

Change Request (CR) 9278 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers.

What You Need to Do

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

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.

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), 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. If any new or modified code has an effective date past the implementation date specified in CR9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR9278 lists only the changes that have been approved since the last code update by CR9125, issued on April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at http://www.wpc-edi.com/Reference on the WPC website.

Changes in RARC List Since CR9125

New Codes - RARC

Code	Modified Narrative	Effective Date
N753	Missing/Incomplete/Invalid Attachment Control Number.	07/01/2015
N754	Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.	07/01/2015
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	07/01/2015
N756	Missing/Incomplete/Invalid point of drop-off address,	07/01/2015
N757	Adjusted based on the Federal Indian Fees schedule (MLR).	07/01/2015
N758	Adjusted based on the prior authorization decision.	07/01/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	07/01/2015

Modified Codes - RARC

Code	Modified Narrative	Effective Date
M47	Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	07/01/2015
MA74	ALERT: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	07/01/2015
N432	ALERT: Adjustment based on a Recovery Audit.	07/01/2015
N22	ALERT: This procedure code was added/changed because it more accurately describes the services rendered.	07/01/2015
M39	ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	07/01/2015
N109	ALERT: This claim/service was chosen for complex review.	07/01/2015
M38	ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	07/01/2015
N381	ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	07/01/2015
MA91	ALERT: This determination is the result of the appeal you filed.	07/01/2015

Deactivated Codes - RARC

Code	Current Narrative	Effective Date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	07/01/2016

***N735- This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.**

Changes in CARC List Since CR9125

New Code - CARC

Code	Modified Narrative	Effective Date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	07/01/2015

Modified Code - CARC

Code	Modified Narrative	Effective Date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.)	11/01/2015

There have been no **deactivated** CARC codes since CR9125.

In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Additional Information

The official instruction, CR9278, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.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" on the CMS website.

Update to Medicare Deductible, Coinsurance and Premium Rates for 2016 (MM9410) (GEN)

MLN Matters® Number: MM9410
Related CR Release Date: November 25, 2015
Related CR Transmittal #: R96GI
Related Change Request (CR) #: CR 9410
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

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) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2016 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

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

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

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

2016 PART A - HOSPITAL INSURANCE (HI)

- Deductible: $1,288.00
- Coinsurance
  - $322.00 a day for 61st-90th day
  - $644.00 a day for 91st-150th day (lifetime reserve days)
  - $161.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- Base Premium (BP): $411.00 a month
- BP with 10% surcharge: $452.10 a month
- BP with 45% reduction: $226.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45% reduction and 10% surcharge: $248.60 a month

2016 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

- Standard Premium: $121.80 a month
- Deductible: $166.00 a year
- Pro Rata Data Amount
  - $118.86 1st month
  - $47.14 2nd month
- Coinsurance: 20 percent

Additional Information

The official instruction, CR 9410, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R96GI.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.

Update to the List of Compendia as Authoritative Sources for Use in the Determination of a "Medically-Accepted Indication" of Drugs and Biologicals Used Off-label in an Anti-Cancer Chemotherapeutic Regimen (MM9386) (DRU)

MLN Matters® Number: MM9386
Related CR Release Date: November 6, 2015
Related CR Transmittal #: R212BP

Related Change Request (CR) #: CR 9386
Effective Date: August 12, 2015
Implementation Date: February 10, 2016

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 9386 which announces that effective for services on or after August 12, 2015, the Centers for Medicare & Medicaid Services (CMS) is adding Wolters Kluwer Lexi-Drugs® to the list of authoritative compendia for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

Background

The *Social Security Act* (Section 1861(t)(2)(B)(ii)(I); (https://www.ssa.gov/OP_Home/ssact/title18/1861.htm) as amended by the *Deficit Reduction Act of 2005* (http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/html/PLAW-109publ171.htm) (Pub. Law 109-171; Section 6001(f)(1)), recognized the following three compendia as authoritative sources for use in the determination of a "medically accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

1. American Medical Association Drug Evaluations (AMA-DE);
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

These authoritative sources could be used in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen, unless:

- The Secretary of Health and Human Services (HHS) determined that the use is not medically appropriate; or
- The use is identified as not indicated in one or more such compendia.

This provision was implemented through instructions to the MACs in the "*Medicare Benefit Policy Manual*" (Chapter 15, Section 50.4.5).

Due to changes in the pharmaceutical reference industry:

- The AHFS-DI was the only remaining statutorily-named compendia available for CMS reference;
- The AMA-DE and USP-DI are no longer published;
- Thomson Micromedex designated Drug Points was the successor to USP-DI; but
- Drug Points has since been deleted from the list of recognized compendia.

In January 2008, CMS established, via the Physician Fee Schedule Final Rule for calendar year 2008:

- A process for revising the list of compendia, as authorized under the *Social Security Act* (Section 1861(t)(2)), and
- A definition for "compendium."

This sub-regulatory process for revising the list of compendia is described in the "*Medicare Benefit Policy Manua*l" (Chapter 15, Section 50.4.5.1).

Based on this process, CMS updated the list in 2008 to include the following four compendia:

1. Existing - American Hospital Formulary Service-Drug Information (AHFS-DI),
2. Effective June 5, 2008 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
3. Effective June 10, 2008 - Truven Health Analytics Micromedex DrugDex, and
4. Effective July 2, 2008 - Elsevier/Gold Standard Clinical Pharmacology.

On August 12, 2015, CMS announced the addition of Wolters Kluwer Lexi-Drugs® to the above list of four compendia used by the Medicare program in the determination of a "medically-accepted indication" for off-label drugs and biologics used in an anticancer chemotherapeutic treatment regimen. This is effective for services on or after August 12, 2015.

Further details on this issue are in the revised Chapter 15, Section 50.4.5.1 of the "*Medicare Benefit Policy Manual*," which is an attachment to CR9386.

Additional Information

The official instruction, CR 9386, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R212BP.pdf on the CMS website.

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

Fee Schedule Updates (GEN)

The 2015 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC JA) Website, http://www.medicarenhic.com/dme/dmfees.aspx.
This quarter the following notices have been posted:

The following Fee Schedules have been added or revised:

- 4th Quarter 2015 Jurisdiction A DME MAC Fee Schedule
- 4th Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2015 Oral Anticancer Drug Fees
- 2nd Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File was revised
- 1st Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File was revised

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

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

CMS News Flash (GEN)

Revised product from the Medicare Learning Network® (MLN)

- *ICD-10-CM/PCS Billing and Payment Frequently Asked Questions*, Fact Sheet, ICN 908974
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD-10BillingandPaymentFAQs.pdf
- *Medicare Claim Review Programs*, Booklet, ICN 006973, Downloadable
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243290.html
- *Medicare Enrollment and Claim Submission Guidelines*, Booklet, ICN 906764, Downloadable and Hard Copy
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1252814.html
- *HIPAA EDI Standards*, Web-based Training (WBT)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
- *DMEPOS Information for Pharmacies*, Fact Sheet, ICN 905711, Downloadable only
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246766.html
- *PECOS Technical Assistance Contact Information*, Fact Sheet, ICN 903766, downloadable
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243418.html
- *PECOS for Provider and Supplier Organizations*, Fact Sheet, ICN 903767, Downloadable only
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243426.html
- *837P and Form CMS-1500*, Web-Based Training (WBT)
  http://learner.mlnlms.com/Catalog/TrainingCatalog.aspx?at=T

New product from the Medicare Learning Network® (MLN)

- *HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules*, Fact Sheet, ICN 909001, downloadable http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909001.html

Electronic Mailing List for those who refer Medicare Beneficiaries for DMEPOS

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

Each Office Visit is an Opportunity to Recommend Influenza Vaccination

Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

- Preventive Services Educational Tool
  https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- Influenza Vaccine Payment Allowances MLN Matters Article
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9299.pdf
- Influenza Resources for Health Care Professionals MLN Matters Article
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1523.pdf
- CDC Influenza website
  http://www.cdc.gov/FLU/

MLN Connects® Provider eNews

MLN Connects® Provider eNews for September 10, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-09-10-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-09-10-eNews.pdf

Countdown to ICD-10

- Updated Results for ICD-10 End-to-End Testing Week in July
- ICD-10 Coding and Clinical Documentation Resources
- New Webcasts Cover Dental, Lab, Pharmacy, and Radiology Services
- Audio Recording and Written Transcript from August 27 MLN Connects Call Available
- Finding ICD-10 Information Online Just Got Easier
- Revised ICD-10 Products Now Available in Hard Copy Format

MLN Connects® National Provider Calls and Events

- Overview of the 2014 Annual Quality and Resource Use Reports Webcast - Last Chance to Register
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call - Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call - Register Now
- Dialysis Facility Compare: Rollout of Five Star Rating Call - Registration Now Open
- 2014 Supplemental QRUR Physician Feedback Program Call - Registration Now Open

Announcements

- HIV Screening for Older Adults and Others with Medicare
- 2014 Annual Quality and Resource Use Reports Available Soon
- CMS to Release CBR on Orthopedic Surgeons' Use of Modifiers 24 and 25 in September

Claims, Pricers, and Codes

- Delay in Implementing Single Chamber and Dual Chamber Cardiac Pacemakers

Medicare Learning Network® Educational Products

- "Skilled Nursing Facility (SNF) Consolidated Billing (CB)" Web-Based Training Course - Revised
- "HIPAA EDI Standards" Web-Based Training Course - Revised

MLN Connects® Provider eNews for September 17, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-09-17-eNews.html

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https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-09-17-eNews.pdf

Countdown to ICD-10

- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Use of Unspecified Codes in ICD-10-CM
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call - Last Chance to Register
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call - Last Chance to Register
- Dialysis Facility Compare: Rollout of Five Star Rating Call - Register Now
- 2014 Supplemental QRUR Physician Feedback Program Call - Register Now
- Improving Medicare Post-Acute Care Transformation Act - Registration Now Open

Other CMS Events

- Physician Compare Public Reporting Information Sessions
- Medicare Learning Network Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund

Announcements

- Medicare-Covered Cardiovascular Disease Preventive Services
- Healthy Aging Month - Discuss Preventive Services with your Patients
- CMS Releases Plan to Address Health Equity in Medicare
- Early Flu Treatment Reduces Hospitalization Time, Disability Risk in Older People
- 2016 PQRS Payment Adjustment and Informal Review Process
- Million Hearts: Cardiovascular Disease Risk Reduction Model Application Deadline Extension

Medicare Learning Network® Educational Products

- "Medicare-Required SNF PPS Assessments" Educational Tool - Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" MLN Matters Article - Revised

MLN Connects® Provider eNews for September 24, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-09-24-eNews.html

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https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-09-24-eNews.pdf

Countdown to ICD-10

- Use ICD-10 to Successfully Bill for Your Services
- Clarifying Questions and Answers Related to the CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities - Update
- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- Claims that Span the ICD-10 Implementation Date
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- Dialysis Facility Compare: Rollout of Five Star Rating Call - Register Now
- 2014 Supplemental QRUR Physician Feedback Program Call - Register Now
- Improving Medicare Post-Acute Care Transformation Act - Register Now
- New MLN Connects National Provider Event Audio Recording and Transcript

Other CMS Events

- Medicare Learning Network Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund
- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- September is Prostate Cancer Awareness Month
- Prepare for DMEPOS Competitive Bidding Round 1 2017: Three Steps to Get Ready
- EHR Incentive Program 2016 Payment Adjustment Fact Sheet for Hospitals Available

Medicare Learning Network® Educational Products

- "PECOS for Physicians and Non-Physician Practitioners" Fact Sheet - Revised
- Medicare Learning Network Product Available In Electronic Publication Format

MLN Connects® Provider eNews for October 01, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-10-01-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-10-01-eNews.pdf

ICD-10

- Coding around the Compliance Date
- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Access the ICD-10 Code Set
- Finding ICD-10 Information Online

MLN Connects® National Provider Calls and Events

- Dialysis Facility Compare: Rollout of Five Star Rating Call - Last Chance to Register
- 2014 Supplemental QRUR Physician Feedback Program Call - Register Now
- Improving Medicare Post-Acute Care Transformation Act - Register Now
- New MLN Connects Event Video Slideshows, Audio Recordings, and Transcripts

MLN Connects Videos

- Video Available on PQRS and VM: What You Need to Know in 2015

Other CMS Events

- Webinar for Comparative Billing Report on Modifiers 24 and 25: Orthopedic Surgeons

Announcements

- Talk to Your Patients about Mental Illness and Depression
- CMS Proposes New Medicare Clinical Diagnostic Laboratory Tests Fee Schedule
- HHS Announces $685 Million to Support Clinicians Delivering High Quality, Patient-Centered Care
- CMS Awards $110 Million to Continue Improvements in Patient Safety
- 2014 Supplemental Quality and Resource Use Reports Available
- MACRA: New Opportunities for Medicare Providers through Innovative Payment Systems
- Getting Started with the Hospice Item Set: Updated Fact Sheet Available
- Access Ordering and Referring Report through data.cms.gov
- Change in Cost Report Appeals Support Contractor for Part A Providers
- New EHR Web Page for Past Program Requirements and Resources
- Guidance on Switching EHR Vendors
- 2016 PQRS Payment Adjustment and Informal Review Process

Medicare Learning Network® Educational Products

- "Medicare Enrollment and Claim Submission Guidelines" Booklet - Revised
- "Medicare Enrollment for Institutional Providers" Fact Sheet - Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for October 08, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-10-08-eNews.html

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https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-10-08-eNews.pdf

ICD-10

- Get ICD-10 Answers in One Place
- 5 Ways to Check Your Claim Status

MLN Connects® National Provider Calls and Events

- 2014 Supplemental QRUR Physician Feedback Program Call - Last Chance to Register
- Improving Medicare Post-Acute Care Transformation Act - Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

Other CMS Events

- MACRA Request for Information Webinars

Announcements

- DMEPOS Competitive Bidding Round 1 2017 Bidding Starts October 15
- HHS Issues Rules to Advance Electronic Health Records with Added Simplicity and Flexibility
- Physician Compare Preview Period Open through November 6
- DMEPOS Fee Schedule PUF Formats and Rural Zip Code File
- October Quarterly Provider Update Available
- Technical Correction to FY 2015 IPF Final Rule
- Participation in EHR Incentive Programs: Updated FAQs

Claims, Pricers, and Codes

- October 2015 OPPS Pricer File Available

Medicare Learning Network® Educational Products

- "How to Access and Use the Medicare Learning Network Learning Management and Product Ordering System (LM/POS)" Fact Sheet - Released
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet - Revised
- "DMEPOS Information for Pharmacies" Fact sheet - Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects® Provider eNews for October 15, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-10-15-eNews.html

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https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-10-15-eNews.pdf

ICD-10

- Use ICD-10 Now
- ICD-10 Ombudsman and ICD-10 Coordination Center Support Your Transition Needs
- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® National Provider Calls and Events

- Improving Medicare Post-Acute Care Transformation Act Call - Last Chance to Register
- Stay Informed about Medicare Program Changes

Other CMS Events

- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- CMS Launches New ACO Dialysis Model
- New Medicare Utilization and Payment Data Available for Medical Equipment, Supplies
- Primary Care Makes Strides in Improving Quality and Costs
- CMS to Release a Comparative Billing Report on Optometry Services in October
- EHR Incentive Program: 2016 Payment Adjustments and Reconsiderations

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1]" Educational Tool - Released
- Medicare Learning Network Products Available in Hard Copy Format
- Medicare Learning Network Product Available In Electronic Publication Format

MLN Connects® Provider eNews for October 22, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-10-22-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-10-22-eNews.pdf

ICD-10

- Learn How to Assign an ICD-10-CM Diagnosis Code with MLN Connects Videos
- Video Slideshow from August 27 MLN Connects Call Available
- 5 Ways to Check Your Claim Status
- Contact List for ICD-10 Questions

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call - Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- EHR Incentive Programs: Recording from Final Rule Webinar Available

Announcements

- HHS Awards more than $240 Million to Expand the Primary Care Workforce
- HHS Awards up to $22.9 Million in Planning Grants for Certified Community Behavioral Health Clinics
- 2016 Value Modifier: Informal Review Request Period Open through November 9
- 2016 PQRS Payment Adjustment: Informal Review Request Period Open through November 9
- IRF Quality Reporting Program Data Submission Deadline: November 15
- LTCH Quality Reporting Program Data Submission Deadline: November 15
- MACRA Request for Information: Comments Accepted through November 17
- Dialysis Facility Compare: Submit your Comments through December 4
- New Survey Process for Duodenoscopes / Endoscopes / Reusable Medical Devices
- Hospice Quality Reporting Program: New Training Modules Available

Claims, Pricers, and Codes

- Mass Adjustments of IRF PPS Claims that Require a Special Wage Index

Medicare Learning Network® Educational Products

- “Infection Control: Environmental Safety” Web-Based Training Course - Released
- “Infection Control: Injection Safety” Web-Based Training Course - Released
- “PECOS for Provider and Supplier Organizations” Fact Sheet - Revised

MLN Connects® Provider eNews for October 29, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-10-29-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-10-29-eNews.pdf

Editor's Note: If you order or refer items or services for Medicare beneficiaries and do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. See the revised *MLN Matters® Special Edition Article #SE1305* (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf). Also, see the revised *MLN Matters Special Edition Article #SE1434* (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1434.pdf) on provider enrollment requirements for writing prescriptions for Medicare Part D drugs. Learn how to enroll to order/refer or prescribe Part D drugs using the 855O and more.

ICD-10

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call - Register Now
- National Partnership to Improve Dementia Care and QAPI Call - Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- Webinar for Comparative Billing Report on Optometry Services
- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- October is National Breast Cancer Awareness Month
- Protect Your Patients against Influenza and Pneumonia
- Hospital Value-Based Purchasing Program: FY 2016 Results
- DMEPOS Fee Schedule DME and PEN Text File Formats - Revised
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: New Public Health Reporting FAQ

Claims, Pricers, and Codes

- Claims Processing Issue for non-Pneumococcal and Influenza Vaccines
- Correction of Mammography Claims
- October 2015 OPPS Pricer File Update

Medicare Learning Network® Educational Products

- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters Article - Revised
- "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A HHA Claims" MLN Matters Article - Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for November 05, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-11-05-eNews.html

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https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-11-05-eNews.pdf

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call - Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call - Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call - Registration Now Open
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call - Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- Physician Fee Schedule: Policy and Payment Changes for CY 2016
- Hospital Outpatient and ASC: Policy and Payment Changes for CY 2016
- ESRD Facilities: Policies and Payment Rates for CY 2016
- HHAs: Payment Changes for CY 2016
- Discharge Planning Proposed Rule Focuses on Patient Preferences
- Final Waivers in Connection with the Shared Savings Program
- DMEPOS Competitive Bidding Round 1 2017: Covered Document Review Date November 16
- Physician Compare Preview Period Extended to November 16
- 2016 Value Modifier: Informal Review Deadline Extended to November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to November 23
- Part D Prescribers Must Enroll in Medicare: Submit Your Application by January 1
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements?
- CMS to Release a Comparative Billing Report on Physical Therapy in November
- November is Home Care and Hospice Month
- Each Office Visit is an Opportunity to Recommend Influenza Vaccination
- Find Information on Medicare-Covered Preventive Services

Claims, Pricers, and Codes

- Colorectal Cancer Screening Claims Processing Issue
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 HH PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- Medicare Learning Network Catalog: November 2015 Version Available
- "ICD-10-CM Diagnosis Codes for Bone Mass Measurement" MLN Matters Article - Released
- "Medicare FFS Claims Processing Guidance for Implementing ICD-10" MLN Matters Article - Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects® Provider eNews for November 12, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-11-12-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-11-12-eNews.pdf

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call - Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call - Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call - Register Now

Other CMS Events

- LTCH Quality Reporting Program: In-Person Provider Training in Baltimore, MD

Announcements

- Three DMEPOS Competitive Bidding Reminders for Round 1 2017
- EHR Incentive Programs Stage 3 Final Rule: Submit Comments by December 15
- New FAQs on Participation in EHR Incentive Programs
- CMS Seeking Comment on MACRA Episode Groups by February 15
- Raising Awareness of Diabetes in November

Claims, Pricers, and Codes

- Pap Smear and PET Scan Claims Editing Incorrectly
- Additional Logic Applied to MDC 14

Medicare Learning Network® Publications

- Selecting Home Health Claims for Probe and Educate Review MLN Matters® Article - Released
- Clinical Laboratory Improvement Amendments Fact Sheet - Revised
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet - Revised
- Products Available in an Electronic Publication Format

MLN Connects® Provider eNews for November 19, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-11-19-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-11-19-eNews.pdf

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call - Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call - Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call - Register Now

Announcements

- Registration for DMEPOS Competitive Bidding Round 1 2017 Closes November 20
- CMS Awards Partnership-Driven Special Innovation Projects to QIN-QIOs
- Reducing Improper Payment: A Collaborative Effort
- Comprehensive Care for Joint Replacement Model
- Revised 2014 Annual QRURs Available
- 2016 Value Modifier Informal Review Deadline Ends November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Ends November 23
- Comments on Discharge to Community Quality Measure due November 23
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements? - Updated
- EHR Incentive Programs: New Public Health Reporting FAQs
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Claims, Pricers, and Codes

- ICD-10 Transition: Clarifications about NCDs and LCDs
- CY 2013 Referring Provider DMEPOS Data - Updated

Medicare Learning Network® Publications

- Complying with Documentation Requirements for Laboratory Services Fact Sheet - New
- Skilled Nursing Facility Prospective Payment System Booklet - Revised
- Product Available in an Electronic Publication Format

MLN Connects® Provider eNews for November 25, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-11-25-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-11-25-eNews.pdf

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call - Last Chance to Register
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call - Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call - Register Now
- ESRD QIP: Payment Year 2019 Final Rule Call - Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- Release of the 2016 DMEPOS Fee Schedules
- December 1 is World AIDS Day: The Time to Act is Now
- Comments on Tobacco Treatment Measures due December 4
- 2016 Value Modifier Informal Review Deadline Extended to December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to December 16

Claims, Pricers, and Codes

- Smoking Cessation Claims Editing Incorrectly
- Home Health Billing Codes Changing January 1

Medicare Learning Network® Publications

- Clarification of Patient Discharge Status Codes and Hospital Transfer Policies MLN Matters® Article - Revised
- Verify Your Profile Information in the Learning Management/Product Ordering System
- New Educational Web Guides Fast Fact

MLN Connects® Provider eNews for December 03, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-12-03-eNews.html

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https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-12-03-eNews.pdf

New Feature: Click to View Articles!

MLN Connects® Events

- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call - Last Chance to Register
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call - Last Chance to Register
- ESRD QIP: Payment Year 2019 Final Rule Call - Register Now

Other CMS Events

- Comparative Billing Report on Physical Therapy Webinar

Announcements

- CMS Updates Quality Strategy
- CMS Awards $110 Million in ESRD Network Funding
- Corrections Being Made to 2016 DMEPOS Fee Schedules
- CMS to Release Comparative Billing Report on Home E/M Services in December
- Hospital IQR and Medicare EHR Incentive Programs: Data Submission Deadline Extended
- PQRS Changes in 2016 Physician Fee Schedule Final Rule
- National Influenza Vaccination Week: December 6 through 12

Claims, Pricers, and Codes

- Extracorporeal Photophoresis and PTA Claims Editing Incorrectly

Medicare Learning Network® Publications

- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool - New
- ICD-10 Website Wheel Educational Tool - Revised
- Hospital Reclassifications Fact Sheet - Revised
- PECOS for DMEPOS Suppliers Fact Sheet - Revised
- Medicare Disproportionate Share Hospital Fact Sheet - Revised
- DMEPOS Quality Standards Booklet - Revised

DME MAC JA's Gift Policy (GEN)

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC JA) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DME MAC JA has a zero tolerance policy regarding gifts - we cannot accept any. If you would like to express your thanks for service you have received from DME MAC JA's representatives, we welcome notes or letters of appreciation in place of gifts.

2016 Jurisdiction A DME MAC Holiday Schedules (GEN)

The **Jurisdiction A Offices** will be observing the following holidays in 2016:

Holiday	Day of the Week	Date
New Year's Day	Friday	January 1
Martin Luther King, Jr. Day	Monday	January 18
Memorial Day	Monday	May 30
Independence Day	Monday	July 4
Labor Day	Monday	September 5
Veterans Day	Friday	November 11
Thanksgiving Day	Thursday	November 24
Friday following Thanksgiving	Friday	November 25
Company-designated Floating Holiday	Friday	December 23
Christmas	Monday	December 26

The **Jurisdiction A Call Center** will be observing the following holidays in 2016:

Holiday	Day of the Week	Date
New Year's Day	Friday	January 1
Martin Luther King Jr. Day	Monday	January 18
Memorial Day	Monday	May 30
Independence Day	Monday	July 4
Labor Day	Monday	September 5
Columbus Day	Monday	October 10
Thanksgiving Day	Thursday	November 24
Day after Thanksgiving	Friday	November 25
Christmas Day	Monday	December 26

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

Billing Instructions - Completing an External Infusion Pump LCD DME Information Form (DIF) for Levodopa-Carbidopa Enteral Suspension - DME MAC Joint Publication (SPE)

A DME Information Form (DIF) which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request. Recently, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have received questions regarding the completion of the External Infusion Pump DIF (DME 09.03) for Levodopa-Carbidopa enteral suspension (Duopa).

For claims with an initial date of service on or after November 15, 2015, suppliers must submit an INITIAL DIF in accordance with the instructions below. For beneficiaries who are currently receiving Duopa, the first claim submitted on or after November 15, 2015 must include a REVISED DIF submitted in accordance with the instructions below.

DIF Questions #1 and #4

These questions require no special instructions, and should be completed as required.

DIF Question #2

Levodopa-Carbidopa enteral suspension is currently billed using HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). When a NOC drug code is billed for use with an external infusion pump, the name of the drug must be printed in response to question #2 on the DIF, and the claim must be accompanied by:

- Description of item or service
- Product name
- Manufacturer name

DIF Question #3

For the route of administration, the supplier must check option #4 - "Other" - as the answer to this question.

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 (https://www.dmepdac.com/contact/index.html).

Correct Coding - 2016 HCPCS Code Annual Update - DME MAC Joint Publication (GEN)

The following tables identify changes to Level II Healthcare Common Procedure Coding System (HCPCS) codes for 2016. The tables contain only the 2016 HCPCS codes that are applicable to items that fall within Medicare DME MAC jurisdiction. There may be other HCPCS code changes for items under the jurisdiction of other Medicare contractors. Consult with those contractors for information regarding HCPCS codes that fall within their areas of responsibility.

All HCPCS code changes are effective for claims with dates of service on or after January 1, 2016.

Code Change Categories

Added Codes/Added Modifiers: These are new codes and modifiers.

Discontinued Codes/Deleted Modifiers: These are codes and modifiers that are discontinued /deleted. These codes and modifiers continue to be valid for Medicare claims with dates of service on or before December 31, 2015.

If there is a direct crosswalk for a discontinued/deleted code or modifier, the crosswalk code is listed in the table. The crosswalked codes are effective for claims with dates of service on or after January 1, 2016.

There is no grace period that allows for submission of a discontinued code/modifier for claims with dates of service in 2016.

Narrative Changes/Revised Modifiers: These are changes in the narrative descriptor for an existing code or modifier.

For products not listed on the DMECS Product Classification Lists, suppliers should evaluate whether a revised narrative changes their coding choices.

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/

Code Tables

The appearance of a code in the tables below does not necessarily indicate coverage. Refer to the applicable Local Coverage Determination for information regarding Medicare reimbursement requirements.

Ankle-Foot/Knee-Ankle-Foot Orthosis

Narrative Changes

Code	Old Narrative	New Narrative
L1902	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, OFF-THE-SHELF	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILIAR, WITH OR WITHOUT JOINTS, PREFABRICATED, OFF-THE-SHELF
L1904	ANKLE ORTHOSIS, ANKLE GAUNTLET, CUSTOM-FABRICATED	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILIAR, WITH OR WITHOUT JOINTS, CUSTOM FABRICATED

Bowel Management

Added Code

Code	Narrative
A4337	INCONTINENCE SUPPLY, RECTAL INSERT, ANY TYPE, EACH

External Infusion Pumps

Added Code

Code	Narrative
J7340	CARBIDOPA 5 MG/LEVODOPA 20 MG ENTERAL SUSPENSION
J9039	INJECTION, BLINATUMOMAB, 1 MICROGRAM
J1575	INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNEGLOBULIN

Immunosuppressive Drugs

Added Code

Code	Narrative
J7503	TACROLIMUS, EXTENDED RELEASE, (ENVARSUS XR), ORAL, 0.25 MG
J7512	PREDNISONE, IMMEDIATE RELEASE OR DELAYED RELEASE, ORAL, 1 MG

Narrative Changes

Code	Old Narrative	New Narrative
J7508	TACROLIMUS, EXTENDED RELEASE, ORAL, 0.1 MG	TACROLIMUS, EXTENDED RELEASE, (ASTAGRAF XL), ORAL, 0.1 MG

Discontinued Code

Code	Narrative	Crosswalk to Code
J7506	PREDNISONE, ORAL, PER 5 MG	J7512

Miscellaneous

Added Code

Code	Narrative
J7999	COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED

Discontinued Code

Code	Narrative	Crosswalk to Code
Q9977	COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED	J7999

Nebulizers

Discontinued Code

Code	Narrative	Crosswalk to Code
A7011	CORRUGATED TUBING, NON-DISPOSABLE, USED WITH LARGE VOLUME NEBULIZER, 10 FEET	NONE

Oral Antiemetic Drugs

Added Code

Code	Narrative
J8655	NETUPITANT 300 MG AND PALONOSETRON 0.5 MG

Discontinued Code

Code	Narrative	Crosswalk to Code
Q9978	NETUPITANT 300 MG AND PALONOSETRON 0.5 MG	J8655

Parenteral Nutrition

Narrative Changes

Code	Old Narrative	New Narrative
B5000	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, RENAL - AMIROSYN RF, NEPHRAMINE, RENAMINE - PREMIX	PARENTERAL NUTRITION SOLUTION COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, RENAL-AMINOSYN-RF, NEPHRAMINE, RENAMINE-PREMIX
B5100	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, HEPATIC - FREAMINE HBC, HEPATAMINE - PREMIX	PARENTERAL NUTRITION SOLUTION COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, HEPATIC, HEPATAMINE-PREMIX
B5200	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, STRESS - BRANCH CHAIN AMINO ACIDS - PREMIX	PARENTERAL NUTRITION SOLUTION COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, STRESS-BRANCH CHAIN AMINO ACIDS-FREAMINE-HBC-PREMIX

Ventilators

Added Code

Code	Narrative
E0465	HOME VENTILATOR, ANY TYPE, USED WITH INVASIVE INTERFACE, (E.G., TRACHEOSTOMY TUBE)
E0466	HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE, (E.G., MASK, CHEST SHELL)

Discontinued Code

Code	Narrative	Crosswalk to Code
E0450	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)	E0465
E0460	NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY	E0466

Code	Narrative	Crosswalk to Code
E0461	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G., MASK)	E0466
E0463	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)	E0465
E0464	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G., MASK)	E0466

Wheelchair Options/Accessories

Added Code

Code	Narrative
E1012	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, CENTER MOUNT POWER ELEVATING LEG REST/PLATFORM, COMPLETE SYSTEM, ANY TYPE, EACH

Narrative Changes

Code	Old Narrative	New Narrative
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, REPLACEMENT ONLY, EACH
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, REPLACEMENT ONLY, EACH

Correct Coding - Ankle Orthoses, With or Without Joints, Prefabricated or Custom Fabricated Coding Verification Review - Joint DME MAC Publication (O&P)

The Centers for Medicare & Medicaid Services HCPCS Workgroup released HCPCS codes effective January 1, 2016. Ankle orthosis codes L1902 and L1904 are revised to include reference to joints. The revised codes read:

L1902 - ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, PREFABRICATED, OFF-THE-SHELF
L1904 - ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, CUSTOM FABRICATED

Ankle orthoses (ankle gauntlet or similar) with joints historically have been listed on DMECS as L2999 (LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED). All ankle gauntlets or similar orthoses with joints listed on DMECS as L2999 will be end dated effective June 30, 2016. All manufacturers must submit a new coding verification review application to the Pricing Data Analysis and Coding Contractor (PDAC) to reclassify those products currently listed as L2999.

The PDAC coding verification application required is the Orthotics 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

The Ankle-Foot/Knee-Ankle-Foot Orthosis LCD (http://www.medicarenhic.com/dme/mrlcdcurrent.aspx) will be updated with these code narrative revisions at a future date.

Correct Coding - Buzzy® - Joint DME MAC Publication (SPE)

The Buzzy® (MMJ Labs) is a palm-sized vibrating bee with a removable ice pack and center slot for an optional tourniquet. Per the manufacturer, when placed proximal to a painful procedure, the combination of cold and vibration block transmission of sharp pain. The device also buzzes like a bee, which provides an auditory distraction. The Buzzy Deluxe Kit includes: neoprene Cold-to-Go Tote, Buzzy® and Bee Stractors™ (distraction device), a Velcro strap, 2 AAA batteries, a set of Blue Gel Wings and two White Ice Wings for longer procedures. Frozen inserts are also included to keep the bag and the frozen wings cold. Buzzy's housing is composed of durable GE Lexan polycarbonate material and may be cleaned with germicidal disposable wipes.

Claims for the Buzzy® billed to the DME MAC must be coded with HCPCS code A9270 (Noncovered item or service) and will be denied as statutorily non-covered (no benefit).

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 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 - Diathermy and Biofeedback Devices - Joint DME MAC Publication (SPE)

Recently HCPCS coding verification reviews have been received for both diathermy and biofeedback devices used as part of inpatient or outpatient facility therapy but that are subsequently given to the beneficiary for use in the home. These items do not meet the payment requirements to be reimbursed as durable medical equipment (DME).

Diathermy and biofeedback therapies are addressed separately by National Coverage Determinations; NCD 150.5 for "Diathermy Treatment" and NCD 30.1 for "Biofeedback Therapy". Both of these services are coded using Current Procedural Terminology (CPT) Codes. The equipment used in association with the provision of these services falls under the jurisdiction of the Medicare A/B Medicare Administrative Contractor (MAC). All diathermy and biofeedback devices are considered not separately billable to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) under the DME Benefit.

The Pricing, Data Analysis and Coding Contractor (PDAC) will assign the coding determination, "NO HCPCS CODE ASSIGNED" to diathermy and biofeedback devices submitted for review. A comment stating "NOT BILLABLE TO THE DME MACS" will be added to each diathermy and biofeedback device posted on the DMECS Product Classification List.

Devices not reviewed or not listed on DMECS must not be billed to the DME MAC. Claims submitted to the DME MACs for diathermy and biofeedback devices will be denied as wrong jurisdiction.

Manufacturers, distributors and suppliers should consult the Medicare A/B MAC contractor for correct billing of these devices.

For questions about coding verification reviews and 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 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 - P-stim® Device - Joint DME MAC Publication (SPE)

Recently the DME MAC contractors have received inquiries about the P-stim® auricular stimulation device (Biegler GmbH). The P-stim® is a miniaturized electro-acupuncture device for use in the practice of acupuncture by qualified practitioners of acupuncture. It provides auriculo-point stimulation treatment over several days. This item is not reimbursable by Medicare. Claims submitted to the DME MACs for the P-stim® device must be coded A9270 (Noncovered item or service).

For questions about coding verification reviews and 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 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 - TOBI® Podhaler™ - Joint DME MAC Publication (SPE)

The TOBI® Podhaler™ (Novartis) is a disposable, hand-held medication dispenser used for the inhalation of tobramycin. This device is not a hand-held nebulizer with a pneumatic compressor and thus is not eligible for reimbursement under the Medicare Durable Medical Equipment Benefit. The TOBI® Podhaler™ is provided as a complete system that includes both the inhaler and tobramycin capsules. Claims for the TOBI® Podhaler™ billed to the DME MAC must be coded with HCPCS code A9270 (Noncovered item or service) and will be denied as statutorily non-covered (no benefit).

HCPCS Code J7682 (Tobramycin, Inhalation Solution, FDA-Approved Final Product, Non-Compounded, Unit Dose Form, Administered Through DME, Per 300 Milligrams) must not be used to bill separately for the tobramycin capsules provided for use in a TOBI® Podhaler™. Separate billing for the TOBI® Podhaler™ device and tobramycin capsules will be denied as unbundling.

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 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 - Tracheostomy Tubes - Joint DME MAC Publication (SPE)

Recently the PDAC and DME MACs have received questions about the proper coding of “customized” tracheostomy tubes. Manufacturers often describe customized tracheostomy tubes as those having a non-standard shaft length or diameter. Variations in construction materials, cuff type, etc. are also sometimes used by manufacturers to define a non-standard product.

The HCPCS codes for tracheostomy tubes are:

A7520 - TRACHEOSTOMY/LARYNGECTOMY TUBE NON-CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH
A7521 - TRACHEOSTOMY/LARYNGECTOMY TUBE CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH

Both codes are all-inclusive. All variations in tracheostomy tube construction such as dimensions, materials, cuffs, connectors etc., including all variation often classified by tube manufacturers as customized tracheostomy tubes are included in HCPCS codes A7520 and A7521.

Miscellaneous or NOC (not otherwise classified) codes such as E1399 (DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS) or A9999 (MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED) must not be used to bill Medicare for any tracheostomy tube. Use of a miscellaneous code to bill Medicare for any tracheostomy tubes is incorrect coding.

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 and Coverage of Ventilators - Revised Effective January 1, 2016 - Joint DME MAC Publication (SPE)

This article has been revised to reflect changes to the 2016 HCPCS codes used for billing Medicare for ventilators. These code changes are effective for claims with dates of service (DOS) on or after January 1 2016.

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

HCPCS Coding

Effective for claims with dates of service on or after January 1, 2016, the following HCPCS codes have been deleted from the HCPCS Code set:

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

Claims for DOS on or after the effective date using these codes will be denied as “invalid code”.

Effective for claims with DOS on or after January 1, 2016, all products classified as ventilators must be billed using one of the following HCPCS codes:

- E0465 - Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
- E0466 - Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

Products previously assigned to HCPCS codes E0450 and E0463 must use HCPCS code E0465. Products previously assigned to HCPCS codes E0460, E0461 and E0464 must use HCPCS code E0466. The PDAC will update the product classification listing in a future update.

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

Coverage

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

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

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

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

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

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

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

Upgrades

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

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

Pricing Category

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

Coverage of Second Ventilator

Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary - same/similar equipment.

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

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

- A beneficiary requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g. positive pressure ventilator with a nasal mask) during the rest of the day.
- A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without two pieces of equipment, the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

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

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

Coverage and Coding - New Oral Antiemetic Drug Varubi™ - Joint DME MAC Publication (DRU)

The U.S. Food and Drug Administration approved Varubi™ (rolapitant) on September 02, 2015. Rolapitant is a substance P/neurokinin1 (NK-1) receptor antagonist medication used to treat nausea and vomiting in patients undergoing emetogenic cancer chemotherapy.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated rolapitant and determined that it is eligible for inclusion in the DME MAC Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) Local Coverage Determination (LCD), effective for claims with dates of service on or after September 02, 2015.

The use of the oral anti-emetic 3-drug combination of an FDA-approved oral NK-1 antagonist and an oral 5HT3 antagonist, in combination with dexamethasone, is covered if, in addition to meeting the statutory coverage criteria specified in the related Policy Article, they are administered to beneficiaries who are receiving one or more of the anti-cancer chemotherapeutic agents listed in the LCD regarding oral anti-emetic coverage.

For dates of service on or after September 02, 2015, claims for rolapitant must be billed using HCPCS code:

Q0181 - UNSPECIFIED ORAL DOSAGE FORM, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR A IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN.

Q0181 must be billed on the same claim with dexamethasone (J8540) and an oral 5HT3 antagonist to qualify for consideration of coverage.

If the three drug combination of an oral 5HT3 antagonist, rolapitant (Q0181) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of the LCD regarding oral antiemetics, a KX modifier must be added to each code. In addition to the diagnosis code corresponding to the beneficiary's cancer diagnosis, claims for these drugs must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (Z51.11).

Any claims for code Q0181 must be accompanied by the name of the drug, the manufacturer, the dosage strength dispensed, the number of capsules and frequency of administration during the covered time period (24-48 hours) as specified on the order. (Note the time span of coverage remains as stated in the LCD). This information should be entered in the narrative field of an electronic claim.

If the three drug combination of rolapitant (Q0181), an oral 5HT3 antagonist and dexamethasone (J8540) are not used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of this policy, the GA or GZ modifier must be added to the claim lines for Q0181 and J8540 and the 5HT3 antagonist. When there is an

expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

Please refer to the DME Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) Local Coverage Determination, related Policy Article and Supplier Manual for further information on coverage, documentation and coding requirements.

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

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

(*Revised October 2015*)

Dear Physician,

For certain specified items of durable medical equipment (see Table A), the *Affordable Care Act* requires:

1. An in-person, face-to-face examination with the treating physician (MD, DO, DPM, PA, NP, CNS)*; and,
2. The treating physician must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered; and,
3. The face-to-face examination must have occurred sometime during the six (6) months prior to the date of the order for the item.

*The *Medicare Access and SCHIP Reauthorization Act of 2015* eliminated the ACA requirement that the NP, PA or CNS face-to-face examination documentation be co-signed by an MD or DO.

The purpose of this letter is to provide additional details of these requirements.

Medicare rules stipulate that a face-to-face examination meeting the requirements discussed below be performed each time a new prescription for one of the specified items is written. A new prescription is required by Medicare:

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

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

Face-to-face Examination Requirements

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

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

For the physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.
- The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:
    - Verify that the in-person visit occurred within the six (6) months prior to the date of their prescription and have documentation of the face-to-face examination that was conducted; and,
    - Provide a copy of the face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item can be delivered.

Prescription (order) Requirements

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

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

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

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

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement.

Date and Timing Requirements

There are specific date and timing issues:

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

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

Sincerely,

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Medical Director, DME MAC, Jurisdiction A
NHIC, Corp.

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

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

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

TABLE A: DME List of Specified Covered Items

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

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

HCPCS Code	Description
E0185	Gel or gel-like pressure mattress pad
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad
E0194	Air fluidized bed
E0197	Air pressure pad for mattress standard length and width
E0198	Water pressure pad for mattress standard length and width
E0199	Dry pressure pad for mattress standard length and width
E0250	Hospital bed fixed height with any type of side rails, mattress
E0251	Hospital bed fixed height with any type side rails without mattress
E0255	Hospital bed variable height with any type side rails with mattress
E0256	Hospital bed variable height with any type side rails without mattress
E0260	Hospital bed semi-electric (Head and foot adjustment) with any type side rails with mattress
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress
E0265	Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress
E0266	Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress
E0290	Hospital bed fixed height without rails with mattress
E0291	Hospital bed fixed height without rail without mattress
E0292	Hospital bed variable height without rail without mattress
E0293	Hospital bed variable height without rail with mattress
E0294	Hospital bed semi-electric (head and foot adjustment) without rail with mattress
E0295	Hospital bed semi-electric (head and foot adjustment) without rail without mattress
E0296	Hospital bed total electric (head, foot and height adjustments) without rail with mattress
E0297	Hospital bed total electric (head, foot and height adjustments) without rail without mattress
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, without mattress
E0302	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress
E0303	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, with mattress
E0304	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, with mattress
E0424	Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (1 months supply)
E0442	Oxygen contents, liquid (1 months supply)
E0443	Portable Oxygen contents, gas (1 months supply)
E0444	Portable oxygen contents, liquid (1 months supply)
E0450	Volume control ventilator without pressure support used with invasive interface
E0457	Chest shell
E0459	Chest wrap
E0460	Negative pressure ventilator portable or stationary
E0461	Volume control ventilator without pressure support node for a noninvasive interface
E0462	Rocking bed with or without side rail
E0463	Pressure support ventilator with volume control mode used for invasive surfaces
E0464	Pressure support vent with volume control mode used for noninvasive surfaces
E0470	Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface
E0471	Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface

HCPCS Code	Description
E0480	Percussor electric/pneumatic home model
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High Frequency chest wall oscillation air pulse generator system
E0484	Oscillatory positive expiratory device, non-electric
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic, large volume
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter
E0585	Nebulizer with compressor & heater
E0601	Continuous airway pressure device
E0607	Home blood glucose monitor
E0627	Seat lift mechanism incorporated lift-chair
E0628	Separate Seat lift mechanism for patient owned furniture electric
E0629	Separate seat lift mechanism for patient owned furniture non-electric
E0636	Multi positional patient support system, with integrated lift, patient accessible controls
E0650	Pneumatic compressor non-segmental home model
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0655	Non- segmental pneumatic appliance for use with pneumatic compressor on half arm
E0656	Non- segmental pneumatic appliance for use with pneumatic compressor on trunk
E0657	Non- segmental pneumatic appliance for use with pneumatic compressor chest
E0660	Non- segmental pneumatic appliance for use with pneumatic compressor on full leg
E0665	Non- segmental pneumatic appliance for use with pneumatic compressor on full arm
E0666	Non- segmental pneumatic appliance for use with pneumatic compressor on half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full-leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg
E0671	Segmental gradient pressure pneumatic appliance full leg
E0672	Segmental gradient pressure pneumatic appliance full arm
E0673	Segmental gradient pressure pneumatic appliance half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel treatment 4 foot panel
E0693	Ultraviolet light therapy system panel treatment 6 foot panel
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0840	Tract frame attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958**	Manual wheelchair accessory, one-arm drive attachment
E0959**	Manual wheelchair accessory-adapter for Amputee
E0960**	Manual wheelchair accessory, shoulder harness/strap

HCPCS Code	Description
E0961**	Manual wheelchair accessory wheel lock brake extension handle
E0966**	Manual wheelchair accessory, headrest extension
E0967**	Manual wheelchair accessory, hand rim with projections
E0968*	Commode seat, wheelchair
E0969*	Narrowing device wheelchair
E0971**	Manual wheelchair accessory anti-tipping device
E0973**	Manual wheelchair accessory, adjustable height, detachable armrest
E0974**	Manual wheelchair accessory anti-rollback device
E0978*	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap
E0980*	Manual wheelchair accessory safety vest
E0981**	Manual wheelchair accessory Seat upholstery, replacement only
E0982**	Manual wheelchair accessory, back upholstery, replacement only
E0983**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control
E0984**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986**	Manual wheelchair accessory, push activated power assist
E0990**	Manual wheelchair accessory, elevating leg rest
E0992**	Manual wheelchair accessory, elevating leg rest solid seat insert
E0994*	Arm rest
E1014	Reclining back, addition to pediatric size wheelchair
E1015	Shock absorber for manual wheelchair
E1020	Residual limb support system for wheelchair
E1028**	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029**	Wheelchair accessory, ventilator tray
E1030**	Wheelchair accessory, ventilator tray, gimbaled
E1031	Rollabout chair, any and all types with castors 5" or greater
E1035**	Multi-positional patient transfer system with integrated seat operated by care giver
E1036**	Patient transfer system
E1037	Transport chair, pediatric size
E1038**	Transport chair, adult size up to 300lb
E1039**	Transport chair, adult size heavy duty >300lb
E1161	Manual Adult size wheelchair includes tilt in space
E1227*	Special height arm for wheelchair
E1228*	Special back height for wheelchair
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233**	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1296*	Special sized wheelchair seat height
E1297*	Special sized wheelchair seat depth by upholstery
E1298*	Special sized wheelchair seat depth and/or width by construction
E1310**	Whirlpool non-portable
E2502**	Speech Generating Devices prerecord messages between 8 and 20 Minutes
E2506**	Speech Generating Devices prerecord messages over 40 minutes
E2508**	Speech Generating Devices message through spelling, manual type
E2510**	Speech Generating Devices synthesized with multiple message methods
E2227**	Rigid pediatric wheelchair adjustable
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength ltwt wheelchair
K0005	Ultra Lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base

HCPCS Code	Description
K0606**	AED garment with electronic analysis
K0730	Controlled dose inhalation drug delivery system

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

This revision incorporates changes in the prescription requirements based upon the *Medicare Access and CHIP Reauthorization Act of 2015*. The original provisions requiring that a physician co-sign a face-to-face examination that was performed by a PA, NP or CNS is removed.

As a condition for payment, Section 6407 of the *Affordable Care Act* (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary within the six (6) months prior to the written order for certain items of DME (Refer to Table A for a list of items).

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

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

The first bullet above, claims for purchases or initial rentals, includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes. This means that all Medicare payment requirements must be met, the same as any other item initially covered by Medicare.

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

ACA 6407 also contained a provision requiring that an MD or DO co-sign the face-to-face examination performed by a PA, NP or CNS. This requirement was eliminated by the *Medicare Access and CHIP Reauthorization Act* (MACRA) of 2015.

Face-To-Face Examination Requirements

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

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

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

For the physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.
- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.
- The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:
    - Verify that the qualifying in-person visit occurred within the 6-months prior to the date of their prescription, and
    - Have documentation of the qualifying face-to-face examination that was conducted.
- The prescriber must provide a copy of the qualifying face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item can be delivered.

Prescription (order) Requirements

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

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

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

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

For any of the specified items affected by this face-to-face requirement to be covered by Medicare, a written, signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

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

Date and Timing Requirements

There are specific date and timing requirements:

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

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

Claim Denial

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

Local Coverage Determinations (LCD)

LCDs that contain items subject to these requirements are:

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

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

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

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

TABLE A: DME List of Specified Covered Items

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

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

HCPCS Code	Description
E0185	Gel or gel-like pressure mattress pad
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad
E0194	Air fluidized bed
E0197	Air pressure pad for mattress standard length and width
E0198	Water pressure pad for mattress standard length and width
E0199	Dry pressure pad for mattress standard length and width

HCPCS Code	Description
E0250	Hospital bed fixed height with any type of side rails, mattress
E0251	Hospital bed fixed height with any type side rails without mattress
E0255	Hospital bed variable height with any type side rails with mattress
E0256	Hospital bed variable height with any type side rails without mattress
E0260	Hospital bed semi-electric (Head and foot adjustment) with any type side rails with mattress
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress
E0265	Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress
E0266	Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress
E0290	Hospital bed fixed height without rails with mattress
E0291	Hospital bed fixed height without rail without mattress
E0292	Hospital bed variable height without rail without mattress
E0293	Hospital bed variable height without rail with mattress
E0294	Hospital bed semi-electric (head and foot adjustment) without rail with mattress
E0295	Hospital bed semi-electric (head and foot adjustment) without rail without mattress
E0296	Hospital bed total electric (head, foot and height adjustments) without rail with mattress
E0297	Hospital bed total electric (head, foot and height adjustments) without rail without mattress
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, without mattress
E0302	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress
E0303	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, with mattress
E0304	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, with mattress
E0424	Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (1 months supply)
E0442	Oxygen contents, liquid (1 months supply)
E0443	Portable Oxygen contents, gas (1 months supply)
E0444	Portable oxygen contents, liquid (1 months supply)
E0450	Volume control ventilator without pressure support used with invasive interface
E0457	Chest shell
E0459	Chest wrap
E0460	Negative pressure ventilator portable or stationary
E0461	Volume control ventilator without pressure support node for a noninvasive interface
E0462	Rocking bed with or without side rail
E0463	Pressure support ventilator with volume control mode used for invasive surfaces
E0464	Pressure support vent with volume control mode used for noninvasive surfaces
E0470	Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface
E0471	Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface
E0480	Percussor electric/pneumatic home model
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High Frequency chest wall oscillation air pulse generator system
E0484	Oscillatory positive expiratory device, non-electric
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic, large volume
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter
E0585	Nebulizer with compressor & heater
E0601	Continuous airway pressure device
E0607	Home blood glucose monitor
E0627	Seat lift mechanism incorporated lift-chair
E0628	Separate Seat lift mechanism for patient owned furniture electric
E0629	Separate seat lift mechanism for patient owned furniture non-electric
E0636	Multi positional patient support system, with integrated lift, patient accessible controls
E0650	Pneumatic compressor non-segmental home model
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure

HCPCS Code	Description
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0655	Non- segmental pneumatic appliance for use with pneumatic compressor on half arm
E0656	Non- segmental pneumatic appliance for use with pneumatic compressor on trunk
E0657	Non- segmental pneumatic appliance for use with pneumatic compressor chest
E0660	Non- segmental pneumatic appliance for use with pneumatic compressor on full leg
E0665	Non- segmental pneumatic appliance for use with pneumatic compressor on full arm
E0666	Non- segmental pneumatic appliance for use with pneumatic compressor on half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full-leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg
E0671	Segmental gradient pressure pneumatic appliance full leg
E0672	Segmental gradient pressure pneumatic appliance full arm
E0673	Segmental gradient pressure pneumatic appliance half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel treatment 4 foot panel
E0693	Ultraviolet light therapy system panel treatment 6 foot panel
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0840	Tract frame attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958**	Manual wheelchair accessory, one-arm drive attachment
E0959**	Manual wheelchair accessory-adapter for Amputee
E0960**	Manual wheelchair accessory, shoulder harness/strap
E0961**	Manual wheelchair accessory wheel lock brake extension handle
E0966**	Manual wheelchair accessory, headrest extension
E0967**	Manual wheelchair accessory, hand rim with projections
E0968*	Commode seat, wheelchair
E0969*	Narrowing device wheelchair
E0971**	Manual wheelchair accessory anti-tipping device
E0973**	Manual wheelchair accessory, adjustable height, detachable armrest
E0974**	Manual wheelchair accessory anti-rollback device
E0978*	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap
E0980*	Manual wheelchair accessory safety vest
E0981**	Manual wheelchair accessory Seat upholstery, replacement only
E0982**	Manual wheelchair accessory, back upholstery, replacement only
E0983**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control
E0984**	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986**	Manual wheelchair accessory, push activated power assist

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

Osteogenesis Stimulator Policy Revision FAQs (SPE)

Question 1: Why have the diagnosis codes been removed from the revised policy?
Answer: The ICD-9 to ICD-10 cross-walk resulted in a policy that was very long and unwieldy. The cross-walked policy was also lacking diagnosis codes for "subsequent encounters". The NCD for osteogenesis stimulators does not contain any diagnosis codes, and the medical directors have adopted the NCD's narrative format in this revision.

Question 2: Do we still have to submit the applicable diagnosis codes on the claims?
Answer: Yes, it is a claim processing system requirement that a diagnosis code(s) must be included on all claims.

Question 3: Do we still need to submit a CMN with the initial claim?
Answer: Yes. The removal of diagnosis codes from the LCD does not change the requirement to submit a properly completed CMN for these items.

Question 4: What diagnosis code(s) should the physician/qualified provider use on the CMN?
Answer: The physician/provider should use an ICD-10 code that is applicable to the particular beneficiary's medical condition. An ICD-10 diagnosis code is not used to determine reimbursement. During a claim review, information contained in the contemporaneous medical record is what is used to justify that the required payment rules are met.

Question 5: With the removal of the ICD-10 diagnosis codes, has any of the coverage criteria for osteogenesis stimulators changed?
Answer: No. Coverage criteria for osteogenesis stimulators remains unchanged.

Speech Generating Devices - Coding Verification Review Requirement - Joint DME MAC & PDAC Publication (SPE)

The Pricing, Data Analysis, and Coding (PDAC) contractor is conducting Coding Verification Reviews for code E2510 (SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS). All products currently listed on the Pricing, Data Analysis, and Coding (PDAC) contractor website with HCPCS code E2510 will be end dated effective May 31, 2016. 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 E2510.

Effective for claims with dates of service on or after June 1, 2016, the only products which may be billed to Medicare using code E2510 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 website: https://www.dmepdac.com/dmecsapp/do/search

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

The Speech Generating Devices Local Coverage Determination and related Policy Article will be updated with this information at a later date.

Standard Documentation Language for Local Coverage Determinations and Related Policy Articles - Revised - Joint DME MAC Publication (GEN)

Note: *This is a revision to the previous article published in October 2014. This version clarifies the requirements for dispensing orders and detailed written orders with respect to start dates and the dates required on orders.*

This information will be added to future revisions of the LCDs.

Many errors reported in DME MAC MR Reviews and CERT Audits arise from problems associated with submitted documentation; consequently, the DME MACs have created a standardized language for use in Local Coverage Determinations and related Policy Articles. Standardized language first appeared in 2012 and with subsequent changes in CMS and DME MAC program instructions, is

being revised with this publication. The updated language will be inserted in the applicable LCDs and related PAs upcoming revisions to these policies.

The standard sections are written in a modular format to allow each policy to contain information relevant to that policy while not including material that does not apply. This article provides a complete listing of all of the documentation requirement modules. All modules may not be used in every LCD. For example, the CMN sections would not be included in the DOCUMENTATION REQUIREMENTS section of an LCD for an item that does not require a CMN.

*****IMPORTANT*****

Many policies contain coverage and documentation requirements that are unique to that specific policy. Such unique information is not included in this article. It is important that suppliers review the actual LCD to be sure to have all of the relevant information necessary and applicable to the item(s) provided.

In several places you will see "placeholders" like "XXX" or "###". Information specific to the policy will be inserted in these spots. Occasionally you may also see "Editor Note" comments. These notes are used to indicate where optional sections may be inserted, when applicable and formatting information.

Standard Language

LCD

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on *Social Security Act* §1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee for Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

DWO Verbiage

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

ACA WOPD

(**Editor Note:** *Insert after DWO section*)

For some items in this policy to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

REFILL REQUIREMENTS

(**Editor Note:** *Use for those LCDs with continuous supplies*)

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (*CMS Program Integrity Manual*, Internet-Only Manual, CMS Pub. 100-08, Chapter 5, Section 5.2.6).

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a XX-month quantity at a time.

DOCUMENTATION REQUIREMENTS

Section 1833(e) of the *Social Security Act* precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing physician's name
- Date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

In some cases, the physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed prescription with a correctly determined prescription date, an item may be shipped or delivered on or after the prescription date (except for items that require written orders prior to delivery).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

ACA 6407 (Prescription Requirements, prior to DWO)

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes specified in the table contained in the Policy Specific Documentation Requirements Section below. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. Refer the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

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

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

With respect to the date on the DWO/WOPD:

1. If the prescriber creates a complete and compliant DWO/WOPD, only a single date - the "order date" - is required. This order date may be the date that the prescriber signs the document (either wet signature or electronic signature)
2. If someone other than the prescriber (e.g., DME supplier) creates the DWO/WOPD then the prescription must be reviewed and, "…personally signed and dated…" by the prescriber. In this scenario two (2) dates are required: an "order date" and a prescriber-entered "signature date".

In some cases, the physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed prescription with a correctly determined prescription date, an item may be shipped or delivered on or after the prescription date (except for items that require written orders prior to delivery).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.
Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.2.3)

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)
(**Editor Note:** *Only for WOPD items*)

A detailed written order prior to delivery (WOPD) is required for XXX. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 -5.9)

The **Coverage Indications, Limitations and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Non-Medical Necessity Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED MEDICAL NEED

For all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial date of service (DOS) to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

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

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

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

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
- Supplier records documenting beneficiary confirmation of continued use of a rental item

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

REFILL DOCUMENTATION (PIM 5.2.5-6)
(**Editor Note:** *Only for policies with items subject to refill requirements*)

A routine refill prescription is not needed. A new prescription is needed when:

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) - The Supplier should assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies) - The supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

This information must be kept on file and be available upon request.

PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

(**Editor Note:** *Some LCDs only have 2 methods of delivery - Delete #3*)

Suppliers are required to maintain POD documentation in their files. For items addressed in this policy there are three methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

<u>Method 1—Direct Delivery to the Beneficiary by the Supplier</u>

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee or the supplier. When the supplier's delivery documents have both a supplier-entered date and a beneficiary or beneficiary's designee signature date on the POD document, the beneficiary or beneficiary's designee-entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD document must contain the information specified above.

Method 3—Delivery to Nursing Facility on Behalf of a Beneficiary

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

Regardless the method of delivery, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary's use were actually provided to and used by the beneficiary must be available upon request.

EQUIPMENT RETAINED FROM A PRIOR PAYER

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if

there is no change in the beneficiary's medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare, the supplier:

1. Must obtain a new POD as described above under "Methods of Delivery" (whichever method is applicable); or,
2. Must obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), attesting that the supplier has examined the DMEPOS item, it is in good working order and that it meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

{*Insert code table*}

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required. Refer to the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

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

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

GENERAL

CERTIFICATE OF MEDICAL NECESSITY (PIM 5.3)
(**Editor Note:** *Only for items requiring CMN*)

A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the physician can enter the other details directly.

(**Editor Note:** *Add specific DIF instructions as needed*)

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

DME INFORMATION FORM (PIM 5.3)
(**Editor Note:** *Only for items requiring a DIF*)

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(**Editor Note:** *Add specific DIF instructions as needed*)

REPAIR/REPLACEMENT (BPM Ch 15, §110.2)
(**Editor Note:** *Applies to all DMEPOS except artificial limbs*)

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above).; and,
2. Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

REPAIR/REPLACEMENT (BPM Ch 15, §120)
(**Editor Note:** *Only applies to Lower Limb Prostheses LCD*)

Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

Medicare payment may be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary. Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must be supported by a new physician's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating physician, either on the order or in the medical record, and must fall under one of the following:

1. A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,
2. An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request. It is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive beneficiary weight or prosthetic demands of very active amputees.

MISCELLANEOUS
Refer to the Supplier Manual for additional information on documentation requirements.

APPENDICIES
PIM citations above denote references to CMS *Program Integrity Manual*, Internet Only Manual 100-08

POLICY ARTICLE
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES
For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on *Social Security Act* §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

DME (**Editor Note:** *Include specific name of DME item*) covered under the Durable Medical Equipment benefit (*Social Security Act* §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

Or

Prosthetic (**Editor Note:** *Include specific name of prosthetic item*) covered under the Prosthetic Devices benefit (*Social Security Act* §1861(s)(8)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

WRITTEN ORDER PRIOR TO DELIVERY
(**Editor Note:** *Only when WOPD required*)

When the supplier is required to have a written order prior to delivery but bills an item without a detailed written order, the item will be denied as statutorily excluded.

Or for Drugs

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as non-covered.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

{*Select codes from table below*}

Face-to-Face Visit Requirements:

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

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

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

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

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

Prescription Requirements:

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

- Beneficiary's name,

- Physician's name
- Date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

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

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

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

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

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

Date and Timing Requirements

There are specific date and timing requirements:

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

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

Claim Denial

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

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

CODING GUIDELINES

(**Editor Note:** *Only use first paragraph when items require PDAC review*)

The only products which may be billed using codes XXX are those for which a written Coding Verification Review has been made by the Pricing, Data Analysis and Coding (PDAC) Contractor and subsequently published on the appropriate Product Classification List.

Suppliers should contact the PDAC Contractor for guidance on the correct coding of these items.

Updated External Infusion Pump Policy - Parenteral Inotropic Therapy FAQs (SPE)

Question 1: Guideline-directed medical therapy (GDMT) is compliance with optimal medical therapy as defined by ACCF/AHA guidelines recommended therapies (primarily Class I recommendations). These include the use of diuretics, ACE inhibitors or ARB antagonists, beta-blockers, aldosterone antagonists, hydralazine & isosorbide dinitrate, and statins, **as appropriate**. How are we supposed to support the word as appropriate? What if the patient could not take a statin due to allergy/intolerance? Does the record have to indicate as appropriate and why a patient did not take one of these drugs?

Answer: "As appropriate" simply means that the course of action is proper, given the set of circumstances. In the specific example cited above, it is obviously inappropriate to give a statin when the patient is allergic or intolerant. Similarly, if the patient has had a cough associated with ACE inhibitors, the policy's use of "as appropriate" would not require the patient to use that class of drugs. However, in such instances, the contemporaneous patient's medical record should clearly note the reasons for deviating from GDMT.

Question 2: The parenteral inotropic drug can be prescribed by someone other than the evaluating cardiologist. How is a prescriber supposed to evaluate that the initial evaluation was performed by a cardiologist with training in the management of advanced heart failure?

Answer: The prescriber should be familiar with the expertise and training of the consultants utilized for the treatment of their advanced heart failure patients.

Question 3: Are there professional certification letters after an MD name that indicate a cardiologist has training in advanced HF?

Answer: Professional certification letters after the name of the evaluating cardiologist are not a requirement. However, the evaluating cardiologist may indicate "FACC", "Board-Certified in Cardiology" or "Board Certified in Advanced Heart Failure and Transplant Cardiology" on their letterheads, progress notes or other documentation.

Question 4: How can the prescriber obtain proof of the cardiologist's credentials?

Answer: Proof of the evaluating cardiologist's credentials is not required prior to claim submission. Upon an audit, evidence of board certification and or an attestation from the evaluating cardiologist may be requested.

Question 5: What type of records would be used to prove this documentation in the medical record to support a supplier claim?

Answer: As noted in the policy, and in response to the questions above, the contemporaneous patient's medical record must support the claim.

LCD and Policy Article Summary for October 01, 2015 - Drafts Released to Final (GEN)

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

- Bowel Management Devices
- External Infusion Pumps

Each of these medical policies will be effective for claims with dates of service on or after October 01, 2015. The notice period start date is October 01, 2015 and the notice period end date is November 30, 2015.

Bowel Management Devices

LCD and Policy Article

Revision Effective Date: 12/01/2015
Draft LCD and Policy Article promoted to final

External Infusion Pumps

LCD

Revision Effective Date: 12/01/2015
Draft LCD promoted to final
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Criteria for reimbursement of intravenous inotropic medication
Added: Denial for Compound Drugs NOC Q9977
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Instructions for Q9977

Policy Article

Revision Effective Date: 12/01/2015
Draft Policy Article promoted to final
CODING GUIDELINES:
Added: Q9977 (Compounded drug NOC)

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.

LCD Revisions Summary for October 8, 2015 (GEN)

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) that have been revised and posted. The policies included are Orthopedic Footwear, Osteogenesis Stimulators and Wheelchair Seating. Please review the entire LCD for complete information.

Orthopedic Footwear

LCD

Revision Effective: 10/01/2015
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY
Added: Inadvertently omitted ICD10's subsequent visit

Osteogenesis Stimulators

LCD

Revision Effective Date: 10/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: References to ICD-10 Codes
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Deleted: ICD-10 Codes

Wheelchair Seating

LCD

Revision Effective: 10/01/2015
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY
Added: Inadvertently omitted ICD10's; G and Q codes, subsequent visit and sequela

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

LCD and Policy Article Summary for October 15, 2015 - Drafts Released to Final (SPE)

Draft Pneumatic Compression Devices Local Coverage Determination and Policy Article has been finalized.

The medical policy will be effective for claims with dates of service on or after December 01, 2015. The notice period start date is October 15, 2015 and the notice period end date is November 30, 2015.

Pneumatic Compression Devices

LCD

Revision Effective Date: 12/01/2015
Draft Released to Final
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
- Added: Explicit statement on E0675 non-coverage
- Added: E0676 benefit exclusion reference in related Policy Article
- Revised: Requirements for Four-Week Trial for Lymphedema
- Revised: Requirements for Six-Month Trial for Chronic Venous Insufficiency
- Revised: E0652 requirements

HCPCS CODES AND MODIFIERS:
- Added: E0675 and E0676

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS
- Revised: Requirements for E0652
- Added: E0675 to ACA 6407 requirements table

Policy Article

Revision Effective Date: 12/01/2015
Draft Released to Final
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
- Added: Prevention of Venous Thrombolism exclusion from coverage
- Added: Statutorily denial language for E0676
- Added: E0675 to ACA 6407 requirements table

CODING GUIDELINES:
- Added: Coding instructions for Sleeves E0656 and E0657
- Added: Coding instructions for E0675
- Added: E0675 to the Coding Verification Review

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

LCD and Policy Article Revisions Summary for October 22, 2015 (SPE)

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. The policy included is Speech Generating Devices. Please review the entire LCD and related PA for complete information.

Speech Generating Devices

LCD

Revision Effective Date: 07/29/2015 (October 2015 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
- Added: SGD definitional language from NCD 50.1
- Added: Capability to download updates
- Added: Gleason Act language for eye gaze accessories

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
- Added: Documentation requirement for SGD and accessories

Policy Article

Revision Effective Date: 07/29/2015 (October 2015 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
- Added: SGD definitional language from NCD 50.1
- Added: Non-coverage statements from NCD 50.1

CODING GUIDELINES:
- Added: Description of HCPCS Code A4601
- Added: Definitions of SGD accessories and examples

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

LCD and Policy Article Revisions Summary for December 3, 2015 (MOB)

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. The policy included is Wheelchair Seating. Please review the entire LCD and related PA for complete information.

Wheelchair Seating

LCD

Revision Effective Date: 10/01/2015
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY
- Added: ICD-10 codes for Stage 1 Pressure Ulcers

DOCUMENTATION REQUIREMENTS
- Removed: Start date verbiage from Prescription Requirements
- Added: Standard documentation language for dates on orders

Policy Article

Revision Effective Date: 10/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
- Removed: Start date verbiage from Prescription Requirements

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

Lower Limb Prostheses - Draft Policy DL33787 - Joint DME MAC Publication (O&P)

On November 02, 2015 CMS announced the convening of an inter-agency panel to address clinical questions associated with the provision of lower limb prostheses. The DME MACs are delaying finalization of the draft Lower Limb Prostheses LCD (DL33787) pending the final report of the panel.

Additional information is available on the CMS website.

Bowel Management Devices Response to Comments (SPE)

The public comment period for the draft local coverage determination for Bowel Management Devices (BMD) closed on August 31, 2015. A public meeting was held on August 26, 2015.

Comments - Renew® Anal Insert

1. The draft LCD did not take into account the latest published, peer-reviewed literature on the safety and efficacy of the device (Lukacz, et.al. Dis Rectum Colon 2015;58:892-898).

   Response: There are only two articles published in the peer-reviewed literature evaluating the safety and efficacy of the Renew® Anal Insert device. The Lukacz article cited by the commenter has several shortcomings as pointed out by the authors:
   - Use of a nonvalidated assessment scale
   - Non-randomized
   - No control comparison group
   - Non-blinded

   In addition to the above points, the Medical Directors also note the following issues:
   - Short treatment time (12 weeks)
   - "Satisfaction" with device only assessed and reported in those completing 12 week trial thus introducing bias by not counting those that dropped out due to dissatisfaction with the device
   - 25% withdrawal rate from study
   - Dropout rate higher for Medicare-age population
     - Average age of those withdrawing - 74.3 (range 55.2 - 85.2)
     - Average age of those completing - 67.2 (range 33.9 - 88.9)
   - 49% self-reported effectiveness rate
   - Study development, implementation, data collection and data analysis funded by manufacturer
   - All authors of the study were paid consultants to manufacturer

   At this time, based on the paucity of literature demonstrating the effectiveness of the Renew® Anal Insert device, the Medical Directors will maintain the current not reasonable and necessary coverage statement.

2. Rectal inserts are not investigational or experimental.

   Response: The Medical Directors agree; however, as noted above, the strength of the peer-reviewed literature does not support Medicare coverage at this time.

3. CMS acknowledges the similarity between urethral inserts and rectal inserts and should afford similar coverage.

   Response: Coverage of one type of device by Medicare does not confer automatic coverage of another device. The strength of the peer-reviewed literature does not support Medicare coverage of the Renew® Anal Insert device at this time.

Comments - Peristeen® Transanal Irrigation (TAI) System

1. The proposed draft uses an incorrect and incomplete definition of "prosthetic device" as applied to the Peristeen® Transanal Irrigation (TAI) System. The Peristeen® Transanal Irrigation (TAI) System should be afforded coverage under the Prosthetic Devices benefit category.

   Response: The Medical Directors disagree. The Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Workgroup has determined that the Peristeen® Transanal Irrigation (TAI) System is not a prosthetic device. Moreover, as noted in the related Policy Article for the draft LCD, it does not meet the definition of durable medical equipment.

   The CMS HCPCS Workgroup held a public meeting on May 28, 2014 to hear comments on the applications for new 2015 HCPCS codes. The CMS HCPCS Workgroup is comprised of members from commercial insurance plans, the Veteran's Administration, CMS and state Medicaid agencies. A summary of the meeting preliminary decisions is available on the CMS.gov website at:

   http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2014-05-28-Supply-Summary.pdf

   The CMS HCPCS Workgroup determined that the preliminary coding determination associated with this request indicated that existing code A4458 'Enema bag with tubing, reusable' adequately describes the product, and the preliminary payment determination associated with this request indicated that the payment rules associated with the existing code apply to this product. Pricing = 00.

   In fecal incontinence, there is a malfunction of the anal sphincter. Based on a review of the Peristeen® product, we do not believe that it replaces the function or structure of the anal sphincter. Similar to other enema systems, it helps with defecation by increasing the fluid in the bowel. The Medical Directors therefore believe that the HCPCS Workgroup determination of benefit category and the pricing indicator of 00 for code A4459 is correct.

External Infusion Pump (EIP) - Response to Comment Summary (SPE)

The public comment period for the draft local coverage determination for External Infusion Pump (EIP) closed on August 31, 2015. A public meeting was held on August 26, 2015.

1. Five commenters suggested a liberalization of the prescribing provider (APP/NP/PA or MD).
   Response: The medical directors agree, and language in the final policy is reflective of that suggestion. However, since coverage encompasses "Bridge" therapy for patients eligible for and awaiting mechanical circulatory support (MCS)/cardiac transplantation, it is the judgment of the medical directors that a cardiologist with training in the management of advanced heart failure must perform the initial evaluation.

2. Two commenters inquired about a diagnosis code (ICD-10) cross-walk.
   Response: The parenteral inotropic therapy section of the draft policy does not contain any ICD-9 diagnoses codes which require a cross-walk to ICD-10 codes. Moreover, the draft policy defines coverage based on the severity of heart failure (Class IV or Stage D) and not on the diagnosis code(s).

3. Two commenters inquired as to what specific documentation will be required to document "improvement in beneficiary symptoms of heart failure while on the selected inotropic drug at the time of discharge from an inpatient or skilled nursing care facility."
   Response: This is not a new requirement. Under the existing policy, it must be clear from the documentation in the beneficiary's medical record that their symptoms of heart failure improved while on the selected drug at the time of discharge from the inpatient or skilled nursing facility. As a reminder, the Centers for Medicare & Medicaid Services (CMS) provides guidance to contractors and providers in the *Program Integrity Manual* (Internet-only Manual 100-08, Chapter 5, §5.7) with respect to documentation in medical records. The PIM §5.7 states (in pertinent part):

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other health care professionals.

4. Four commenters suggested coverage expansion to include patients with New York Heart Association (NYHA) Class IIIb/ACC Stage C heart failure.
   Response: Current ACCF/AHA heart failure guidelines are not supportive (2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Clyde W. Yancy, MD, MSc, FACC, FAHA; Mariell Jessup, MD, FACC, FAHA; Biykem Bozkurt, MD, PhD, FACC, FAHA; et al. J Am Coll Cardiol. 2013;62(16):e147-e239.), and the final policy will not expand coverage. One commenter submitted one reference to support their contention that inotropes do not increase mortality in this sub-group of patients. The citation was a review article, which did not specifically address patients with NYHA Class IIIb/ACC Stage C heart failure (Guglin M, Kaufman M. International Journal of General Medicine 2014:7 237-251). Three commenters did not submit any literature in support of their recommendation.

5. One commenter requested clarification on the credentials of the "prescribing practitioner".
   Response: The policy requires that the initial evaluation be performed by a cardiologist with training in the management of advanced heart failure.

6. One commenter suggested modifying the draft language regarding "continued need", in order to accommodate beneficiaries in rural areas.
   Response: The medical directors agree that some health care facilities in rural areas may not have structured heart failure teams, and language in the final policy is reflective of that suggestion.

7. One commenter suggested clarifying the language regarding Guideline Directed Medical Therapy (GMDT).
   Response: The draft policy GDMT language requires documentation of the use of **appropriate**, primarily Class I ACCF/AHA guideline recommended therapies for this group of patients; prior to a trial of parenteral inotropic therapy.

Response to Comments to Accompany LCD for Pneumatic Compression Devices (SPE)

1. Comment: Some commenters noted that the LCD should provide coverage for pneumatic compression devices (PCDs) to include those for peripheral arterial disease (PAD). Other commenters proposed limited PCD coverage for PAD.
Response: The medical directors disagree. When the DME Contractor Medical Directors published the Proposed LCD for PCDs in 2011, there had been a period of several years when we had regularly received requests for coverage of PCDs for PAD from a number of those treating these conditions, suggesting the technology and its acceptance had significantly advanced and was becoming more generally accepted. Many at the DME Open Public Meeting in August 2011 and in multiple written comments supported this position. Several commenters took the position that the LCD should include coverage of PCDs for *all* PAD, and not be restricted to those who would otherwise qualify for a surgery but were medically ineligible.

This final policy does not allow for coverage of PCDs for PAD of any severity. In more closely and serially reviewing the statements and guidelines from nearly all of the major cardiovascular and surgical societies, support for the use of this technology is not found, even for limited use. For this reason we are not at this time adding routine coverage for PCDs for PAD.

Continuing literature searches since the date of the draft release have shown no long-term studies supporting that outcomes using a PCD are comparable to the accepted standard of using a surgical revascularization where possible and no major cardiovascular or surgical societies have adopted guidelines taking this position. We received limited journal copies, anecdotal case-reports and brief series information to support the use of this technology as a temporizing or supportive measure for those with advanced disease who are otherwise ineligible for surgery, but here as well, there are no sizeable, long-term studies of efficacy. The medical directors extensively again reviewed all submitted literature as well as coverage decisions by major agencies, health service research entities and insurers (see in the LCD under **Sources of Information and Basis for Decision**). Of these, *only* <u>*one*</u>, from Ireland's Health Information and Quality Authority takes a position supporting any coverage, and that is equivocal, indicating "...more research is needed to confirm...a *potentially* beneficial treatment for people at risk of amputation who are not candidates for revascularization...remains unproven." After this reassessment, we have concluded it is not reasonable and necessary to add coverage of arterial compression devices (E0675) at this time.

2. Multiple commenters suggested diagnostic findings and tests that in their opinion could confirm eligible beneficiaries for PCDs for PAD as a possible alternative to attestation that the beneficiary would otherwise be a candidate for surgery.
Response: There was little consistency to these recommendations. Had we pursued coverage of arterial compression at this time, we would have needed to continue the "otherwise be a candidate for surgery" criterion. Currently, there is no consensus on the usefulness of available diagnostic tests to demonstrate the predictive value of arterial PCD.

3. Several commenters recommended allowing coverage of an E0652 PCD for secondary lymphedema of any etiology, with or without ulcers, when diagnostic criteria are met and the E0650 or E0651 has been ineffective at controlling the lymphedema. It was recommended that documentation of trained and supported daily use of a carefully fitted E0650 or E0651 for a minimum of 4 weeks without significant clinical response should be sufficient to evidence the need for the E0652 device. It was recommended the documentation include a detailed description of the therapies recommended in conjunction with the pump as well as provide objective clinical details of why E0650/E0651 device and adjunct therapies were not effective.
Response: The CMS National Coverage Decision (280.6) has determined, "The only time that a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber."

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

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

4. Several commenters raised a concern that the draft LCD conflicts with NCD 280.6 for PCDs by being more restrictive than the NCD in the coverage afforded to causes of lymphedema.
Response: The revised LCD broadens the allowed indications and thereby specifically addresses any concern in this area. There is no conflict with the revised LCD and the NCD.

5. One commenter recommended that an inability to tolerate compression bandaging for venous ulcers should be an immediate indication for venous compression regardless of the length of time the ulcers have been present.
Response: This is not an option for the DME MACs under NCD 280.6.

6. One commenter recommended that the six-month period of conservative therapy for venous stasis ulcers be reduced to four months. Other commenters also objected to the six-month requirement.
Response: This is not an option for the DME MACs under NCD 280.6.

7. Several commenters recommended that PCDs should be covered for chronic venous insufficiency even in the absence of ulcers.
Response: This is not an option for the DME MACs under NCD 280.6. However, the coverage of lymphedema from various causes has been broadened which will likely accomplish much of what these commenters desire.

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

9. One commenter recommended that an E0652 be allowed for unilateral limb edema, documented to be unresponsive to use of E0651/E0650 coupled with other more conservative measures, on a prior authorization basis.
Response: This recommendation is beyond the scope of the current LCD and Policy Article revisions.

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

11. Quite a number of commenters had recommendations and/or concerns about the rapidity and duration of inflation and deflation times for arterial compression devices, indicating these are critical variables in their functional efficacy and that a number of the products on the market seeking coverage do not have comparable functional efficacy. Others had concerns that the manufacturing requirements for arterial compression devices were not adequately addressed, including a number of very detailed and well-documented observations, reports of research on various parameters and peer-reviewed articles on these topics
Response: Coverage of arterial compression devices (E0675) is not being added at this time.

12. Multiple commenters objected to the requirement that the ordering of an E0675 was being restricted to a vascular surgeon.
Response: Coverage of arterial compression devices (E0675) is not being added at this time.

13. Several commenters pointed out that angiographic dye may be contraindicated in some patients and therefore alternative diagnostic methods for severity of arterial disease are necessary.
Response: Coverage of arterial compression devices (E0675) is not being added at this time.

14. Several commenters offered recommendations and/or concerns about the recertification of the need for PCDs for arterial compression.
Response: Coverage of arterial compression devices (E0675) is not being added at this time.

15. Several commenters indicated podiatrists should be an eligible provider type to order PCDs, rather than have ordering providers limited to physicians (MD, DO) and physician extenders (NP, PA & CNS). Specifically, in response to the proposed fall 2014 revision released in September 2014, intended to be effective 11/01/2014, it was pointed out by multiple stakeholders and societies, including representatives of the American Podiatric Medical Association, that the language of the LCD was more restrictive than many state scope of practice requirements.
Response: We agree. This was one of several important reasons for withdrawal of the proposed fall 2014 revision. The language has been changed to be specifically consistent with state scope of practice requirements.

16. One commenter indicated PCDs are very effective in his vascular surgery practice without needing to use or try more conservative measures first and on that basis they should be a first-line therapy for this condition.
Response: The Medical Directors disagree. Many therapies and testing modalities *may* be effective for conditions which would otherwise respond to simpler, conservative measures. The logic of medical necessity indicates that such interventions should be used in series, first using simpler measures shown by accepted clinical practice to often be effective, unless there is a clear evidence basis to skip these simpler measures for the specific clinical circumstances.

17. One commenter pointed out the word "endoscopic" should be changed on page four.
Response: We agree. The language has been changed.

18. Two commenters pointed out that the CMN for pneumatic compression pumps, CMS Form 846 (DME Form 04.04B), does not track with the NCD and LCD requirements which causes confusion in submitting claims.
Response: We agree, but this is currently beyond the scope of this LCD and Policy Article revision.

19. Several commenters pointed out that the proposed fall 2014 revision required a patient to present with "chronic and severe" lymphedema of 6 months duration before any potential qualification for PCD and that this is more restrictive than the NCD or draft

LCD, which both require failure of 4 weeks conservative therapy and did not stratify by severity. Further the LCD did not define "severe" lymphedema nor did it refer to accepted lymphedema staging stratification.
Response: The Medical Directors agree and acknowledge this was an error, one of the reasons for our withdrawal of the proposed fall 2014 revision, and we thank the several sources who brought this to our attention. This has been corrected and clarified in the current future LCD.

20. Commenters pointed out that the proposed fall 2014 revision required that conservative therapy "must include the component of Manual Lymphatic Drainage (MLD) which is more restrictive than the NCD."
Response: The language has been changed to reinforce the current clear standard of care that MLD should be used and taught for self-application when available but otherwise is not a requirement.

21. One comment objected that the proposed fall 2014 revision indicates "PCDs are not covered if there is any improvement after use of conservative therapy." The concern is that "delaying implementation of therapeutic interventions in this manner does not represent sound clinical practice. Minimal improvement may not be clinically meaningful. Clinical interventions are made when the clinician determines that the patient, while perhaps exhibiting some incremental improvement, is not achieving the level of therapeutic goals that is appropriate in a given timeframe."
Response: If there is improvement, it follows that the improvement may continue with current therapy. The logical end-point of conservative therapy may only be determined by serial re-examinations. If improvement fails to continue as documented by these serial re-examinations, then a PCD may be covered.

22. One comment objected that the proposed fall 2014 revision inappropriately "requires medications as part of conservative therapy."
Response: The language has been changed to indicate medications should be used as clinically indicated.

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

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings resulted in a CDR of 50.6%. A summary of findings was published on the NHIC, Corp. Website on July 30, 2015. Based on this result, a widespread prepayment review was continued.

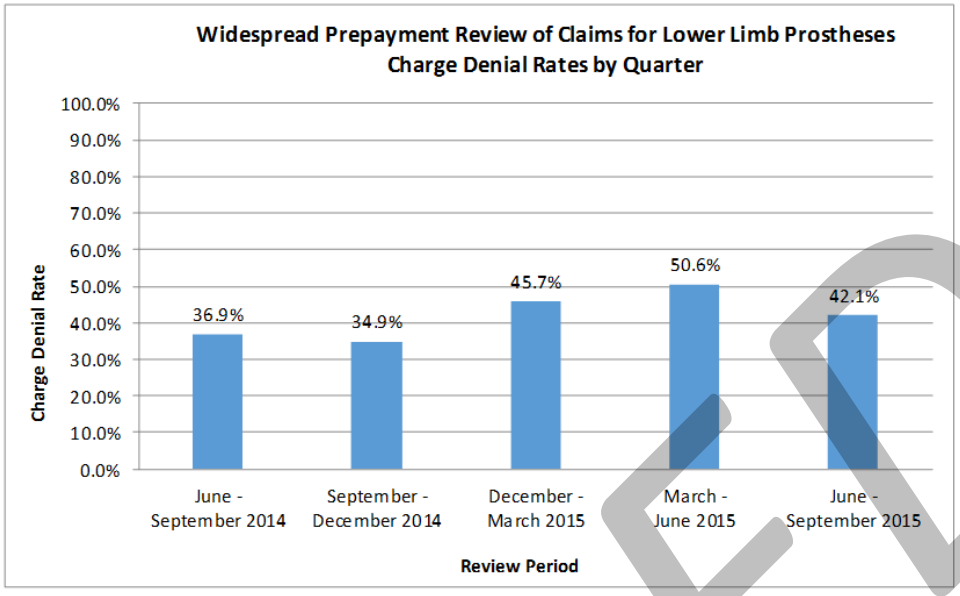
Current Review Results

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.

The review involved prepayment complex medical review of 118 claims submitted by 89 suppliers for claims processed May 29, 2015 to September 03, 2015. Responses to the Additional Documentation Request (ADR) were not received for 28 (24%) of the claims. For the remaining 90 claims, 53 claims were allowed and 37 were denied resulting in a claim denial rate of 41%. The overall Charge Denial Rate was 42.1%.

Charge Denial Rate Historical Data

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



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

- 18% of the denied claims had no medical record information submitted

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

- 7% of the denied claims had medical records submitted but the records did not justify the functional level of the billed item(s)

Proof of Delivery

- 7% of the denied claims were missing a valid Proof of Delivery. Proof of Delivery was missing items delivered; items must be sufficiently detailed to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)

Reason for Replacement

- 17% of the denied claims had no statement or reason for replacement either on the physician's order or in the medical documentation

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, verifying that the beneficiary received the items that were billed; The prosthetist's evaluation/assessment and clinical documentation detailing the functional level of the items billed; Clinical documentation to support functional level of the device and to corroborate the prosthetist's records.
Missing: Information by the ordering physician, either on the Detailed Written Order or in the medical record, demonstrating the reason for replacement.

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 detailing the functional level of the items billed.

Missing: Clinical documentation to support functional level of the device and to corroborate the prosthetist's records. Proof of Delivery was missing which verifies 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, verifying that the beneficiary received the items that were billed; and the prosthetist's evaluation/assessment documentation detailing the functional level 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 supplier's 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@hpe.com

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: http://www.medicarenhic.com/dme/mr.aspx

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 (L33787) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/mrlcdcurrent.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
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/mobile/index.html
- CERT Errors
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Lower Limb Prostheses Documentation Reminder for Physicians
  http://www.medicarenhic.com/viewdoc.aspx?id=2951

- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (posted 10/23/2014, 01/29/2015, 04/23/2015, 07/30/2015)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

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

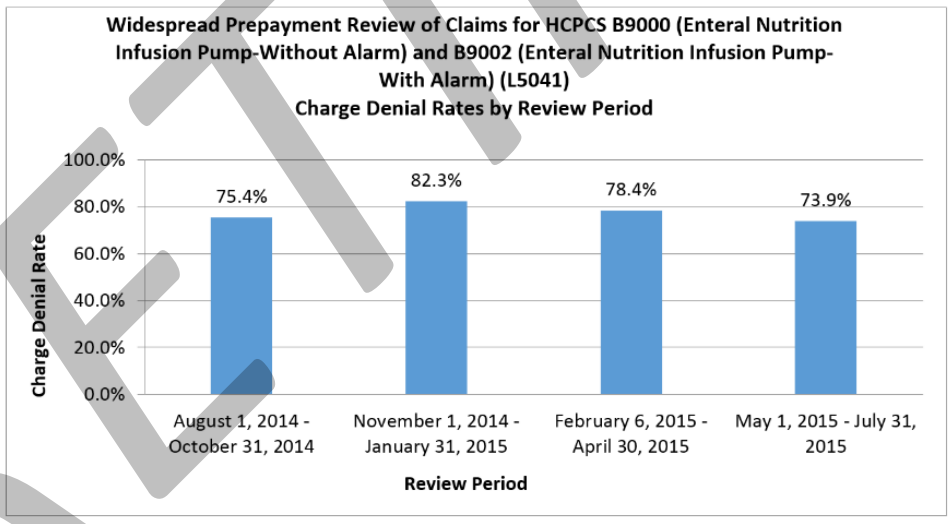
Historical Review Results

DME MAC A Medical Review continues to review Enteral Nutrition Infusion Pump-Without Alarm (B9000) and Enteral Nutrition Infusion Pump-With Alarm (B9200), based on the results of the previous prepayment widespread review. The result of the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed is the Charge Denial Rate (CDR). The previous review included claims reviewed February 01, 2015 - April 30, 2015, which resulted in 78.4% CDR.

Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 and B9002. These findings include claims processed primarily from May 01 thru July 31, 2015. The review involved prepayment complex medical review of 821 claims submitted by 115 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 251 (31%) of the claims. For the remaining claims, 148 claims were allowed, and 422 were denied/partially denied resulting in a claim denial rate of 74% and a CDR of 73.9%.

Charge Denial Rate Historical Data



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

- 4% of the claims denied for statutory denial - did not meet prosthetic benefit requirement
- 31% of the denied claims did not have any medical record documentation submitted

- 19% claims had insufficient clinical documentation that demonstrates that the beneficiary meets the prosthetic benefit of enteral nutrition per requirements being

Note: *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*

Proof of Delivery

- 22% of the denied claims had no Proof of Delivery (POD)
- 14% of the claims had incomplete delivery information
  - 8% No proof of delivery for supplies billed
  - 6% Proof of delivery was not sufficiently detailed to identify the item(s) being delivered

Detailed Written Order Issues

- 31% of the denied claims did not include a detailed written order
- 8% of the denied claims had incomplete detailed written orders
  - Date of the detailed order was incomplete (missing order date)
  - Detailed order submitted does not meet record keeping principles
  - Signed and dated after claim submission date
  - Signature and date stamps are not allowed
  - Unable to read clinician signature date
- 3% Physician signature and no signature log, could not be authenticated

DME Information Form (DIF)

- 12% of the denied claims did not include a DIF
- 3% of the denied claims did not include the Enteral Pump HCPCS code on the DIF

Claim Examples

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

Example 1:

Received: Medical documentation that supports the prosthetic benefit and enteral infusion pump, proof of delivery
Missing: Detailed written order, DIF

Example 2:

Received: Detailed written order, DIF, that supports the prosthetic benefit
Missing: Authenticated physician's signature on supplier generated detailed written order, signature date on the detailed written order, and proof of delivery with signature and date of delivery

Example 3:

Received: Detailed written order, proof of delivery
Missing: DIF, Medical documentation that supports diabetic enteral formula and enteral infusion pump

Next Step

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

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

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

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for enteral nutrition infusion pump 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 06/26/2014, 09/25/2014, 12/18/2014, 03/26/2015, 06/26/2015)
  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

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

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed is the Charge Denial Rate (CDR). The previous quarterly findings covered the period from January 01, 2015 through March 31, 2015 and resulted in a CDR of 78.1%.

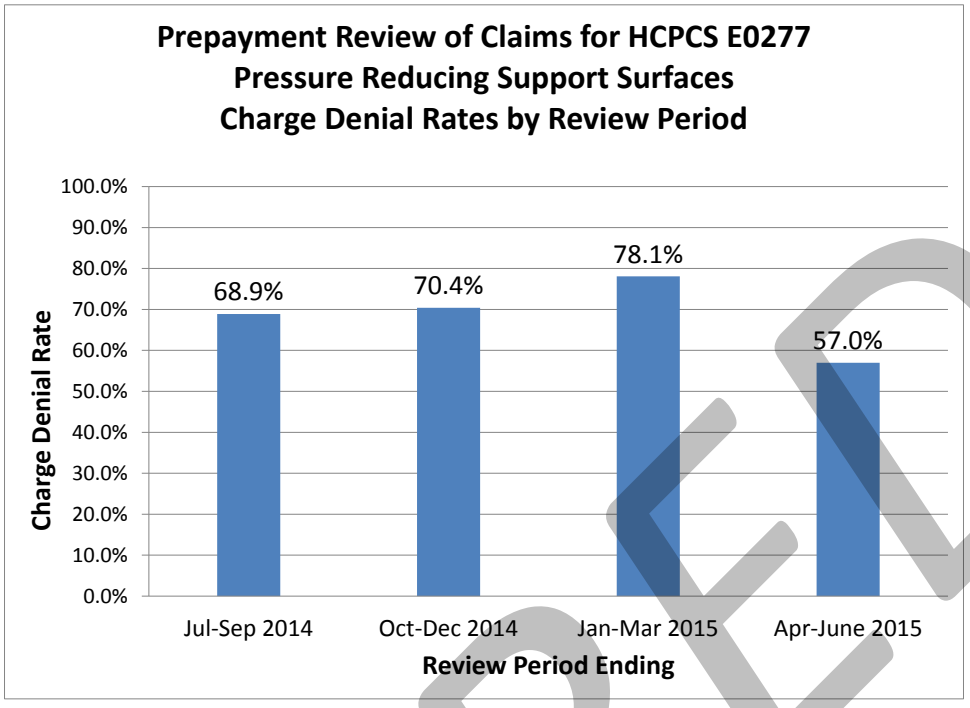
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277). These findings include claims with dates processed from April 01, 2015 through June 30, 2015.

The review involved prepayment complex medical review of 121 claims submitted by 57 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 40 (33%) of the claims. For the remaining 81 claims, 36 were allowed and 45 of the claims were denied. This resulted in a claim denial rate of 56%, and a CDR of 57.0%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Medical Documentation

- 28% of the denied claims did not meet one or more of the three coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, or
    2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
- 5% of the denied claims did not include medical documentation.
- 1% of the denied claims included medical documentation that was illegible.

Written Order Prior to Delivery

- 6% of the denied claims included a written order prior to delivery that was missing an order date/start date.
- 3% of the denied claims included a written order prior to delivery that did not include a narrative description or a brand name/model number of the item being dispensed.
- 3% of the denied claims were missing a written order prior to delivery.
- 1% of the denied claims included a written order prior to delivery that was illegible.

Proof of Delivery Issues

- 3% of the denied claims included proof of delivery that was missing the beneficiary's (or designee) signature.
- 2% of the denied claims were missing a proof of delivery.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Group 2 Pressure Reducing Support Surface claims:

Example 1
Received:
- A written order prior to delivery which includes the beneficiary's name, date of the order and the start date, if start date is different from the date of the order, physician's name, detailed description of the item(s), and physician signature and signature date;
- Medical records consisting of wound center notes.
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:
- Wound center notes/medical documentation which included information that the beneficiary met the coverage criteria.
- Proof of delivery which includes a delivery date that is the same as the date of service.

Example 2
Received:
- Medical records consisting of hospital records;
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:
- A written order prior to delivery which includes the beneficiary's name, date of the order and the start date, if start date is different from the date of the order, physician's name, detailed description of the item(s), and physician signature and signature date;
- Hospital records/medical documentation which included information that the beneficiary met the coverage criteria.
- Proof of delivery which includes a delivery date that is the same as the date of service.

Example 3
Received:
- A written order prior to delivery which includes the beneficiary's name, date of the order and the start date, if start date is different from the date of the order, physician's name, detailed description of the item(s), and physician signature and signature date;
- Medical records consisting of hospital records.
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:
- A written order prior to delivery which includes a detailed description of the item(s);
- Hospital records/medical documentation that included information that the beneficiary met the coverage criteria.
- Proof of delivery which included a delivery date that is the same as the date of service.

Next Step

NHIC, DME MAC A, will be ending the widespread prepayment review of Group 2 Support Surfaces (E0277), but will continue to monitor billing patterns.

Educational References

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

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

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

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

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

- Results of Widespread Prepayment Review for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277) (posted 02/25/2014, 05/29/2014, 09/25/2014, 11/26/2014, 02/26/2015, 05/29/2015)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

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

- Supplier Self Audits
  http://www.medicarenhic.com/dme/selfaudits.aspx

- Live Line Chat (Monday 9:00am - 11:00am and Thursday 1:00pm - 3:00pm) - The Monday chat sessions provide the opportunity to ask billing, policy, documentation and other general questions to the Outreach & Education Team
  http://www.medicarenhic.com/dme/rcseminars.aspx

Results of Widespread Prepayment Review for HCPCS Code L1940 (Ankle-Foot Orthosis) (O&P)

Historical Review Results

This is the first DME MAC JA Medical Review probe for Ankle-Foot Orthosis, HCPCS L1940. This review was initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

Current Review Results

DME MAC Jurisdiction A has completed the prepayment probe review of claims for Ankle-Foot Orthosis, HCPCS L1940.

The review involved prepayment complex medical review of 114 claims submitted by 97 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 34 (30%) of the claims. For the remaining 80 claims, 20 of the claims were allowed and 60 of the claims were denied. This resulted in a claim denial rate of 75%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate (CDR) of 78.5%.

Primary Reasons for Denial

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

Clinical Documentation

- 23% of the denied claims did not include clinical documentation
- 11% of the denied claims did not provide documentation to support the medical necessity of a custom fabricated orthosis, rather than a prefabricated orthosis
- 6% of the denied claims included medical records that were not authenticated by the author
- 6% of the denied claims were missing medical records from the treating physician
- 5% of the denied claims did not meet the basic coverage criteria for beneficiaries with weakness or deformity of the foot and ankle, who:
  1. Require stabilization for medical reasons, and
  2. Have the potential to benefit functionally

Detailed Written Order

- 13% of the denied claims were missing a detailed written order
- 8% of the denied claims included a detailed written order that was missing an order date/start date

- 6% of the denied claims included a detailed written order that was missing the additions to the base code
- 4% of the denied claims included a detailed written order that was missing the physician's name
- 4% of the denied claims included a detailed written order that was missing the item to be ordered
- 3% of the denied claims included a detailed written order that did not include a narrative description or a brand name/model number of the item being ordered

Proof of Delivery

- 18% of the denied claims were missing a proof of delivery
- 8% of the denied claims included a proof of delivery that was missing the delivery address
- 3% of the denied claims included a proof of delivery that did not include a narrative description or a brand name/model number of the item being dispensed
- 3% of the denied claims included a proof of delivery that did not include a quantity of the item delivered
- 3% of the denied claims included a method I proof of delivery in which the delivery date was different than the date of service

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with L1940 Ankle-Foot Orthoses claims:

Example 1

Received:

- A detailed written order which includes the beneficiary's name, date of the order, physician's name, base code of item ordered, and physician signature and signature date
- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the beneficiary met the coverage criteria

Missing:

- A detailed written order which includes the additions to the base code being ordered
- Proof of delivery

Example 2

Received:

- A detailed written order which includes the beneficiary's name, date of the order, physician's name, detailed description of the item(s), and physician signature and signature date
- Clinical documentation consisting of orthotist notes
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed

Missing:

- Medical records from the treating physician

Example 3

Received:

- Proof of delivery which includes the beneficiary's name, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed

Missing:

- A detailed written order which includes the beneficiary's name, date of the order, physician's name, detailed description of the item(s), and physician signature and signature date
- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the beneficiary met the coverage criteria
- Proof of delivery which includes a delivery address

Next Step

Based on the results of this prepayment probe review, DME MAC JA will continue with a prepay complex widespread medical review of claims for Ankle-Foot Orthoses, HCPCS L1940.

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@hpe.com

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for L1940 Ankle-Foot Orthoses claims. Please ensure that the responsible supplier staff are aware of, and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- Ankle-Foot/Knee-Ankle Foot Orthoses LCD
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- Supplier Self Audits
  http://www.medicarenhic.com/dme/selfaudits.aspx

Results of Widespread Prepayment Review for HCPCS Code L4360 (Pneumatic Walking Boot) (O&P)

Historical Review Results

This is the first DME MAC JA Medical Review probe for Pneumatic Walking Boot, HCPCS L4360. This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

Current Review Results

DME MAC Jurisdiction A has completed the prepayment probe review of claims for Pneumatic Walking Boot, HCPCS L4360.

The review involved prepayment complex medical review of 156 claims submitted by 123 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 61 (39%) of the claims. For the remaining 95 claims, 2 of the claims were allowed and 93 of the claims were denied. This resulted in a claim denial rate of 98%. 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 96.7%.

Primary Reasons for Denial

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

Clinical Documentation

- 97% of the denied claims did not meet the coverage criteria for a custom fitted item
- 15% of the denied claims did not include clinical documentation
- 5% of the denied claims did not contain clinical documentation that demonstrated the beneficiary required the item requested
- 4% of the denied claims included medical records that were not authenticated by the author

Detailed Written Order

- 52% of the denied claims were missing a detailed written order
- 5% of the denied claims included a detailed written order that was missing an order date/start date

- 3% of the denied claims included a detailed written order that did not include a narrative description or a brand name/model number of the item being ordered

Proof of Delivery

- 63% of the denied claims were missing a proof of delivery
- 11% of the denied claims included a proof of delivery that was missing the delivery address

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 L4360 Pneumatic Walking Boot claims:

Example 1

Received:

- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the beneficiary met the basic coverage criteria

Missing:

- A detailed written order which includes the beneficiary's name, date of the order, physician's name, base code of item ordered, and physician signature and signature date
- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the item was custom fitted
- Proof of delivery

Example 2

Received:

- A detailed written order which includes the beneficiary's name, date of the order, physician's name, detailed description of the item(s), and physician signature and signature date
- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the beneficiary met the basic coverage criteria
- Proof of delivery which includes the beneficiary's name, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed

Missing:

- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the item was custom fitted
- Proof of delivery which includes a delivery address

Example 3

Received:

- A detailed written order which includes the beneficiary's name, date of the order, physician's name, detailed description of the item(s), and physician signature and signature date
- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the beneficiary met the basic coverage criteria
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed

Missing:

- Clinical documentation consisting of orthotist notes and physician's medical records, which included information that the item was custom fitted

Next Step

Based on the results of this prepayment probe review, DME MAC JA will continue with a prepay complex widespread medical review of claims for Pneumatic Walking Boot, HCPCS L4360.

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@hpe.com

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for L4360 Pneumatic Walking Boot claims. Please ensure that the responsible supplier staff are aware of, and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- Ankle-Foot/Knee-Ankle Foot Orthoses LCD
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Supplier Self Audits
  http://www.medicarenhic.com/dme/selfaudits.aspx
- Correct Coding - Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces)
  http://www.medicarenhic.com/viewdoc.aspx?id=2645

Results of Widespread Prepayment Review for Milrinone (HCPCS Code J2260) (DRU)

Historical Review Results

This is the second DME MAC A widespread prepayment medical review for Milrinone (HCPCS Code J2260). This medical review was initiated due to errors identified by a DME MAC A Medical Review Probe. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered the period of February 2015 through April 2015, and reported a CDR of 73.4%.

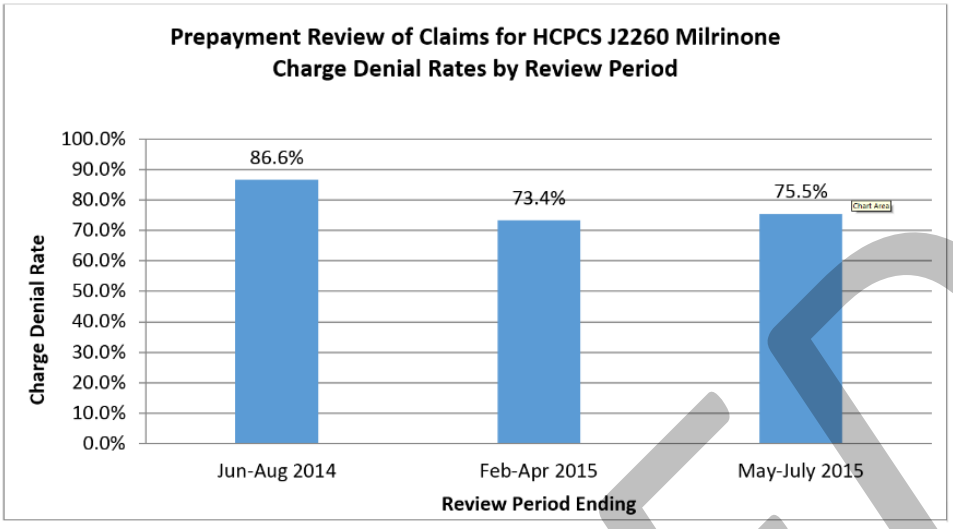
Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for Milrinone (J2260). These findings include claims processed primarily from May through July 2015.

The review involved prepayment complex medical review of 91 claims submitted by 31 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 16 (18%) of the claims. For the remaining 75 claims, 15 claims were allowed (20%) and 60 were denied/partially denied resulting in a claim denial rate of 80%. The overall CDR was 75.6%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

Based on the review, the following are the primary reasons for denial. Note that the percentages 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

- 12% of the denied claims were missing clinical information to support medical necessity.
  - No medical records were submitted
- 51% of the denied claims did not meet all eight coverage criteria as listed in the External Infusion Pumps LCD (L5044):
  1. Dyspnea at rest or with minimal exertion is present despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g., hydralazine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant), and

  2. Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):
     i. Dobutamine - - 2.5-10 mcg/kg/min
     ii. Milrinone - - 0.375-0.750 mcg/kg/min
     iii. Dopamine - - less than or equal to 5 mcg/kg/min, and

  3. Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), performed within 6 months prior to the initiation of home inotropic therapy showing (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b)at least a 20% increase in CI and/or at least a 20% decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion, and

  4. There has been an improvement in beneficiary well-being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly, and

  5. In the case of continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in the hospital, or in the case of intermittent infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management, and

  6. Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home, and

7. The beneficiary is maintained on the lowest practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first 3 months of therapy, and

8. The beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy are routinely assessed and documented in the beneficiary's medical record.

Detailed Written Order

- 13% of the denied claims were missing the detailed written order.
- 40% of the denied claims had an incomplete or invalid detailed written order. The following are common issues identified:
  - Missing a start date
  - Missing the frequency of use
  - Missing the route of administration
  - Missing the number of refills

Proof of Refill Request Issues

- 51% of the denied claims were missing a proof of refill
- 12% of the denied claims had an incomplete or invalid proof of refill
  - Missing documentation demonstrating that supplies are nearly exhausted

Proof of Delivery Issues

- 20% of the denied claims were missing proof of delivery
- 49% of the denied claims had an incomplete or invalid proof of delivery. The following are common issues identified:
  - Unable to associate the supplier proof of delivery records to a delivery service record (Method II)
  - Milrinone delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier(Method I)
  - Milrinone shipped either before or after the date of service of the claim when the item is shipped via a shipping service or delivery service (Method II) directly to a beneficiary
  - The units of service billed were more than the units of service delivered
  - The units of service billed and delivered were significantly higher than the amount of drug ordered.

DME Information Form (DIF) issues

- 5% of the denied claims were missing a DIF

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with milrinone (J2260) claims:

Example 1:

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and start date, detailed description of the item, treating physician's signature and date, dosage concentration, route of administration, frequency of use, quantity to be dispensed, number of refills; proof of refill request; proof of delivery; and a completed DIF.
Missing: The clinical documentation did not demonstrate that the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record.

Example 2:

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and/or start date, detailed description of the item, treating physician's signature and date, dosage concentration, quantity to be dispensed, number of refills; clinical documentation that showed the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record; proof of refill request; proof of delivery; and a completed DIF.
Missing: The frequency of use and the route of administration on the detailed written order. Missing documentation on the proof of refill submitted that demonstrates that the beneficiary has nearly exhausted their supply of medication.

Example 3:

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

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

Next Step

NHIC, DME MAC A, will be ending the widespread prepayment review of Milrinone (J2260), but will continue to monitor billing patterns.

Educational References

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

- External Infusion Pumps LCD (L5044) and Policy Article (A19713)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Live Line Chat
  http://www.medicarenhic.com/dme/rcseminars.aspx
- Results of Widespread Prepayment Review of Claims for Milrinone (J2260) (Posted: 11/26/2014, 06/25/2015)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

Results of Widespread Prepayment Review for Nebulizers (HCPCS Code E0570) (SPE)

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered the period of February 2015 through April 2015, and reported a CDR of 76.2%.

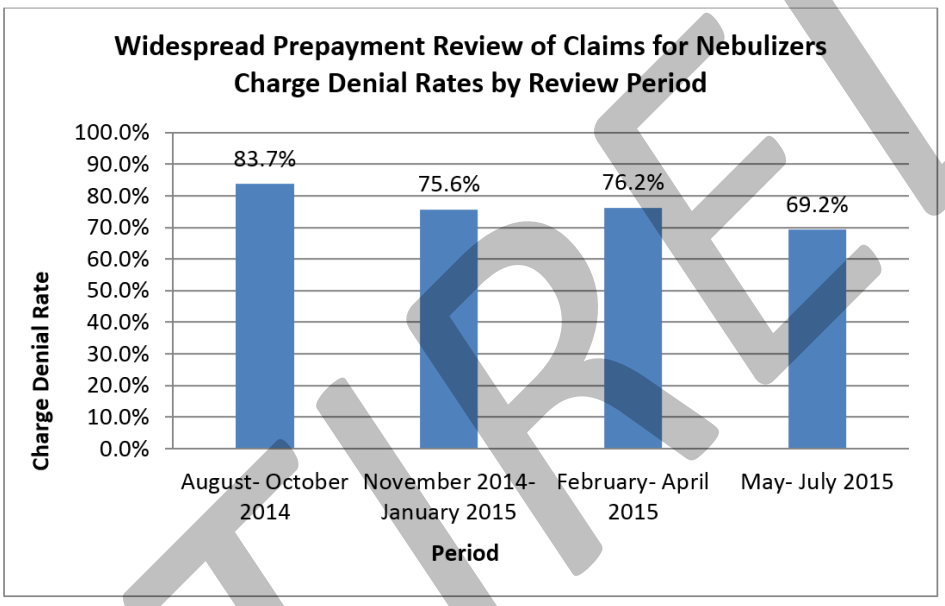
Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from May 2015 through July 2015.

The review involved prepayment complex medical review of 1,554 claims submitted by 546 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 403 (26%) of the claims. For the remaining 1,151 claims, 226 claims were allowed (20%) and 925 were denied/partially denied resulting in a claim denial rate of 80%. The overall CDR was 69.2%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Clinical Documentation Issues

- 19% of the denied claims were missing clinical documentation to support reasonable and necessary.
  - No medical records were submitted
- 32% of the denied claims had insufficient or incomplete clinical documentation. The following are common 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 did not contain enough detailed clinical information to demonstrate that the item is reasonable and necessary
  - 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 or signature log submitted
    - Unsigned typed note with physician's typed name only

Written Order Prior to Delivery (WOPD)

- 2% of the denied claims did not contain a written order prior to delivery.

- 40% of the denied claims had an incomplete or invalid written order prior to delivery. The following are common issues identified:
  - Missing the prescribing practitioner's National Provider Identifier (NPI)
  - Ordering practitioner signature date was after the item(s) were delivered
  - Insufficient evidence (i.e. date stamp, fax date, etc.) within the documentation to show that the supplier received the written order prior to delivering the item(s)

Proof of Delivery Issues

- 4% of the denied claims were missing proof of delivery.
- 9% of the denied claims had an incomplete or invalid proof of delivery. The following are common issues identified:
  - Illegible copy of proof of delivery
  - Missing sufficiently detailed description to identify the item(s) being delivered
  - Missing beneficiary (or designee) signature when item(s) are delivered directly by the supplier to the beneficiary
  - Nebulizer (first month rental) delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier (Method I)
  - Nebulizer (first month rental) shipped either before or after the date of service of the claim when the item(s) is shipped via a shipping service or delivery service (Method II) directly to a beneficiary

Claim Examples

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

Example 1:

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's signature, date of signature, physician's NPI number, sufficient fax stamp that shows supplier received the WOPD before the item(s) were delivered and clinical notes.
Reason for Denial: Clinical notes do not explain reasonable and necessary use of a nebulizer and there was no mention of a payable medical condition for an E0570 nebulizer compressor used with Albuterol. Missing a proof of delivery.

Example 2:

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

Example 3:

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item(s) to be dispensed, physician's signature, date of signature, physician's NPI number, clinical notes and proof of delivery
Reason for Denial: The physician's signature date on the WOPD is after the item(s) 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 item(s). Proof of delivery submitted shows that the item(s) were delivered before the date of service.

Next Step

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

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

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@hpe.com

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information. Decision Desktop can be accessed through the following link: http://www.medicarenhic.com/dme/mr.aspx

Educational References

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

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective July 2013 (A24944)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review of Claims for E0570 (Posted 09/25/2014, 12/18/2014, 03/26/2015, 06/25/2015
  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 Error Articles
  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
- Live Line Chat (Monday 9:00am - 11:00am and Thursday 1:00pm - 3:00pm) - The Monday chat sessions provide the opportunity to ask billing, policy, documentation and other general questions to the Outreach & Education Team.
  http://www.medicarenhic.com/dme/rcseminars.aspx

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

Historical Review Results

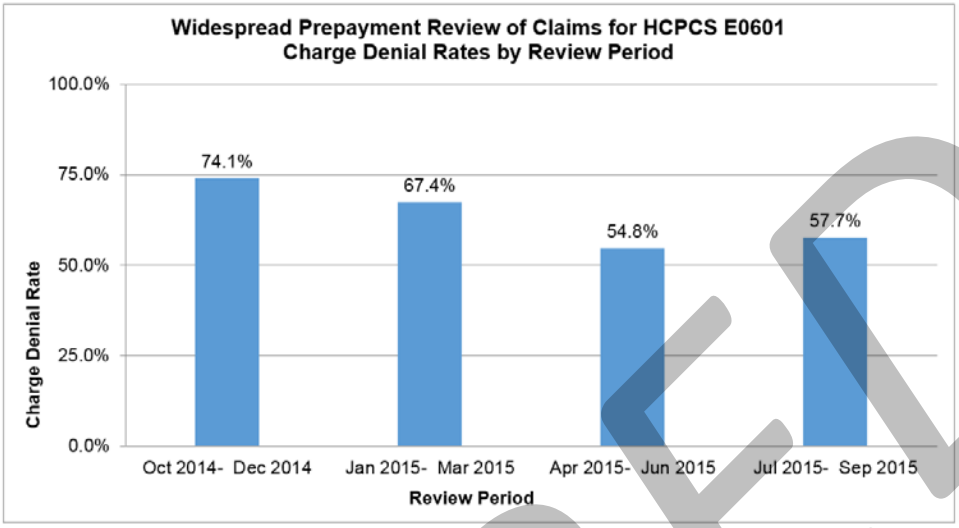
This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered claims reviewed from April 2015 through June 2015, and reported a CDR of 54.8%.

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from July 2015 through September 2015. This review involved prepayment complex medical review of 1372 claims submitted by 352 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 282 (21%) of the claims. Of the 1091 claims for which responses were received, 338 claims were allowed and 753 were denied/partially denied. This resulted in a claim denial rate of 69%. The overall CDR was 57.7%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Face-to-Face Clinical Evaluation Documentation Issues

- 29% of the denied claims had insufficient Face-to-Face clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP LCD. The insufficient clinical documentation included:
  - Missing Face-to-Face
  - Untimely Face-to-Face
  - Face-to-Face does not justify payment by documentation submitted. Clinical documentation provided did not reflect the need for the care provided or no detailed narrative in the clinical documentation describing symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores
  - Face-to-Face is illegible due to poor fax quality or illegible handwriting
  - Medical documentation contains a missing signature by clinician.

  Scenarios included:
  A. Beneficiaries seeking initial coverage of a PAP device
  B. Beneficiaries seeking PAP replacement following the 5 year RUL
  C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare

  An E0601 device is covered when the beneficiary has a Face-to-Face clinical evaluation by treating clinician prior to the sleep test to assess the beneficiary for Obstructive Sleep Apnea per PAP LCD. For beneficiaries entering FFS Medicare, a sleep test prior to the Face-to-Face is acceptable. For beneficiaries seeking PAP replacement following the 5 year RUL, a sleep test does not need to be submitted.

Detailed Written Order/Written Order Prior to Delivery Issues

- 21% of the denied claims had an incomplete Written Order Prior to Delivery for PAP device E0601. Included in these results for incomplete Written Order Prior to Delivery were orders which were missing either:
  A. Beneficiary's name
  B. The E0601 PAP device ordered
  C. The prescribing practitioner's National Provider Identification (NPI)
  D. The signature of the prescribing practitioner
  E. The date of the order
  F. Signature date.

G. A date of receipt demonstrating supplier received the Detailed Written Order on or before the Delivery

- 51% of the claims had an incomplete Detailed Written Order for PAP accessories. Included in these for incomplete Detailed Written Order were orders which were missing either:
  A. Beneficiary's name
  B. Physician's name
  C. Date of the order and the start date, if start date is different from start of order
  D. Detailed description of item(s) ordered
  E. Physician signature and signature date

Also included in this calculation are orders which contain incompatible combination of items that did not have a valid detailed written order with the specific items provided, and replacement items ordered on the initial E0601 claim which are not allowed.

Sleep Study Documentation Issues

- 11% of the denied claims did not include a copy of the original Sleep Test that meets the Medicare coverage criteria
- 3.5% of the denied claims were missing Sleep Study interpretation per the PAP LCD

Training Documentation Issues

- 4.5% of the denied claims did not include evidence of training on the PAP device
- 11.8% of the denied claims did not include evidence of beneficiary training (by entity conducting the test) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a Face-to-Face demonstration, via video, or telephonic instruction and noted in the record

Delivery Issues

- 2% of the denied claims were missing Proof of Delivery
- 7.7% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or beneficiary's signature. (Refer to article: *Proof of Delivery Reminder* found in the below *Educational References* section)

Claim Examples

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

Example 1:

Received: A Detailed Written Order/Written Order Prior to Delivery, a Sleep Test that meets the Medicare coverage criteria, evidence of Training on the PAP device, Proof of Delivery containing replacement items, and Face-to-Face clinical evaluation by the treating physician

Requirement for Replacement Items: Suppliers must not deliver refills without a refill request from a beneficiary. Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. (Refer to article: *Items Provided on a Recurring Basis and Refill Requirements* found in the below *Educational References* section)

Example 2: (Initial coverage of PAP)

Received: Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, and incomplete Proof of Delivery, evidence of Training on the PAP device and a diagnostic Sleep Test

Incomplete/Insufficient: Proof of Delivery is missing a sufficient description of item(s) delivered. Unable to identify item(s) delivered.

Example 3:

Received: A Detailed Written Order/Written Order Prior to Delivery, a Face-to-Face clinical evaluation by treating physician, Home Sleep Study, Proof of Delivery, and evidence of Training on the PAP device

Missing: Documentation submitted did not include information to support that the beneficiary received instruction for the application and use of a portable sleep monitoring device for a home sleep study either by Face-to-Face, video or telephonic instruction.

Next Step

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

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

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

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

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

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

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables the direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: http://www.medicarenhic.com/dme/mr.aspx

Educational References

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

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review of Claims for HCPCS E0601 (Continuous Positive Airway Pressure Devices) (posted 08/27/15, 05/29/15, 02/26/15, 11/21/14)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding general coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Physician's Corner Checklists
  http://www.medicarenhic.com/dme/mobile/index.html
- Items Provided on a Recurring Basis and Refill Requirements - Reminder
  http://www.medicarenhic.com/viewdoc.aspx?id=2933
- Proof of Delivery Reminder
  http://www.medicarenhic.com/viewdoc.aspx?id=2928

Results of Widespread Prepayment Review of Claims for Lumbar-Sacral Orthoses, HCPCS Codes L0631/L0637 (O&P)

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered the period of March 2015 through May 2015 and resulted in a CDR of 81.8%.

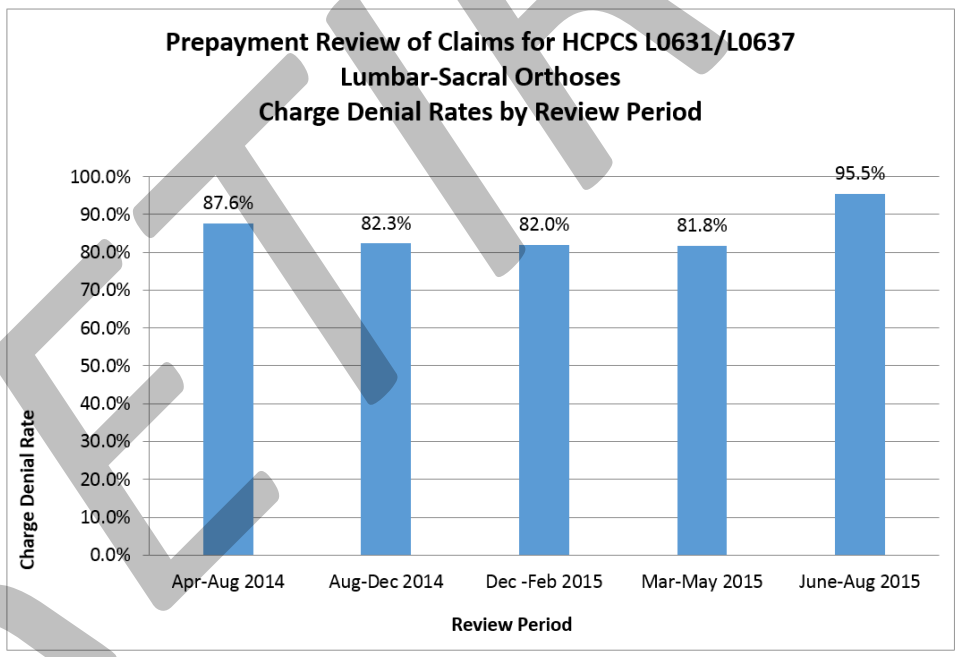
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Lumbar-Sacral Orthoses (HCPCS codes L0631 and L0637). These findings include claims processed primarily from June 2015 through August 2015.

The review involved prepayment complex medical review of 1,068 claims submitted by 357 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 500 (47%) of the claims. For the remaining 568 claims, 17 claims were allowed and 551 claims were denied resulting in a claim denial rate of 97%. The overall CDR was 95.5%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Detailed Written Orders Issues

- Denied claims were missing a Detailed Written Order (DWO) (10.8%)
- Denied claims included an incomplete DWO (26%)
    - DWOs submitted were not legible and/or did not list beneficiary name (2%)

- DWOs missing start date and/or signature date (2.5%)
- DWOs were missing a detailed description of the requested Lumbar Sacral Orthotic (s) The detailed description in the written order may be either a narrative description or a brand name/model number (10%)

Medical Record Documentation Issues

- Denied claims missing the clinical documentation to support medical necessity (6%)
- Denied claims upon review of clinical documentation (30%)
  - Medical documentation was not authenticated by the clinician conducting the exam (6%)
  - Clinician notes submitted did not support medical necessity. The documentation submitted did not demonstrate the treatment of an illness or injury to improve functioning of the spine or trunk on the body (24%)

Proof of Delivery Issues

- Denied claims were missing the Proof of Delivery (POD) (9%)
- Proof of Delivery (POD) included delivery documentation was missing required elements (8%)
  - Delivery documentation (Method 1) did not include signature of beneficiary or beneficiary's representative; unable to determine if beneficiary received items billed (1%)
  - Dates of service do not match shipping/receipt dates for items, as defined within LCD (L33790) (1%)
  - Delivery documentation does not include delivery address (3%)
  - Delivery documentation does not specify the requested Lumbar-Sacral-Orthosis, and it is unclear from the description which orthotic is being delivered. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary. (3%)

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 completed DWO, clinical documentation, and a POD.
Missing: Physician/Clinician signature on documentation. Clinical documentation was dictated but not signed/reviewed by the clinician.

Example 2:

Received: The supplier submitted a completed DWO, POD, and supplier notes.
Missing: Clinical documentation to support the beneficiary's medical need for the requested item. Clinical notes are required as part of the submitted documentation. Supplier notes, even when signed by the ordering physician are not considered part of the medical record for Medicare payment purposes.

Example 3:

Received: The supplier submitted a DWO, handwritten clinical documentation, and a POD.
Missing: The handwritten clinical documentation and signature are not legible, and contain multiple dates of entry. It is not clear from this documentation if the requested LSO is medically necessary, and who the author of the documentation is.

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@hpe.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.

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: http://www.medicarenhic.com/dme/mr.aspx

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 (L33790)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Results of Prepay Probe for Lumbar-Sacral Orthoses
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Supplier Self Audits
  http://www.medicarenhic.com/dme/selfaudits.aspx
- Spinal Orthoses Physicians Checklist
  http://www.medicarenhic.com/dme/mobile/index.html

Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (OXY)

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed result is the Charge Denial Rate (CDR). The previous quarterly findings covered the period of April 01, 2015 through June 30, 2015 and resulted in a CDR of 58.3%.

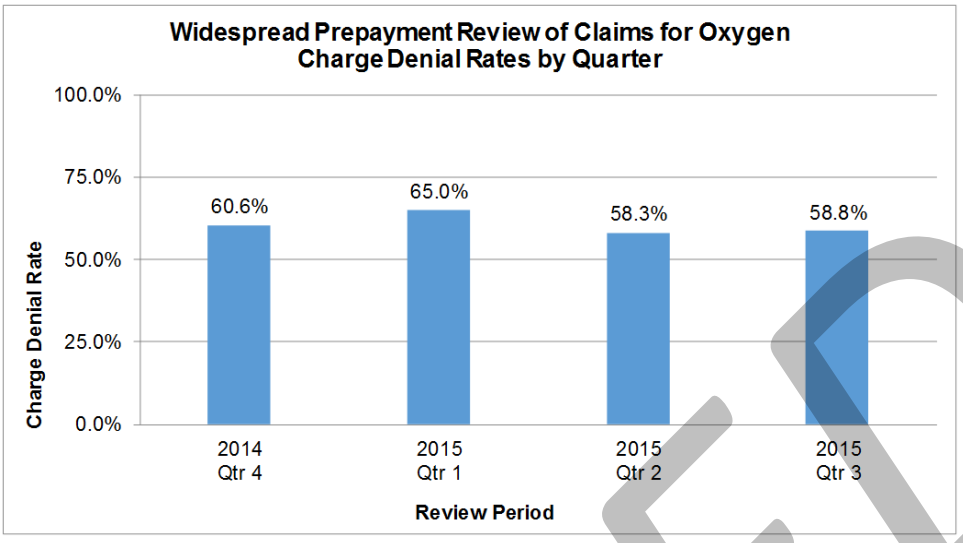
Current Review Results

The DME MAC Jurisdiction A has completed a widespread prepayment review of claims for Oxygen and Oxygen Equipment (HCPCS codes E1390, E0431, and E0439). These findings cover claim process dates primarily from July 01, 2015 through September 30, 2015.

The review involved prepayment complex medical review of 1,371 claims submitted by 161 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 793 (58%) of the claims. For the remaining 578 claims, 204 claims were allowed and 374 were denied resulting in a claim denial rate of 65%, and a CDR of 58.8%.

Charge Denial Rate Historical Data

The following percentages depict the CDR from previous quarters to current:



The Coverage Indications, Limitations and/or Medical Necessity section of the Oxygen and Oxygen supplies LCD states:

Home oxygen is covered only when both the reasonable and necessary criteria are met. Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated in the LCD, and
3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
    a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
    b. If the qualifying blood gas study is not performed during an inpatient stay, the reported test must be performed while the beneficiary is in a chronic stable state - i.e. not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L33797 and related Policy article for additional information.

Primary Reasons for Denial

The following are the primary reasons for denial.

Written Order Prior to Delivery Requirements Not Met (33%):

Documentation did not meet the written order prior to delivery requirements for items E0431 and E0439 outlined in LCD L33797 or dates of service on or after January 01, 2014 for the following reasons:

- No evidence, by date stamp or similar, that the supplier received the detailed written order prior to delivery (35%)
- Detailed written order was signed after the date of delivery (31%)
- Detailed written order was received after the date of delivery (23%)
- Detailed written order was missing a detailed description of the DME item(s) ordered (19%)
- No detailed written order was submitted (12%)
- Detailed written order was missing the prescribing practitioner's NPI (11%)
- Correction was made to the detailed written order without the author's initials and the date of the correction (7%)
- Detailed written order was missing the order date (2%)
- Detailed written order was received by the supplier prior to the signature date (2%)

Missing Documentation (43%):

Missing required physician visit per Local Coverage Determination (LCD) L33797:

- 16% - Missing treating physician visit within 30 days prior to the initial certification date

Missing qualifying blood gas study per LCD L33797

- 10% - No medical documentation to support the blood gas study reported on the CMN

Missing required Certificate of Medical Necessity (CMN) per LCD L33797:

- 14% - Missing a valid initial CMN
  - Initial CMN not submitted
  - Initial CMN missing required information or required information was illegible
  - Initial CMN contained corrections that did not include a single strikethrough, the author's initials and the date of the correction

Missing valid proof of delivery per LCD L33797

- 2% - Missing valid proof of delivery
  - Proof of delivery not submitted
  - Date of delivery did not match the initial date of service
  - Proof of delivery missing the items delivered

Clinical Documentation Issues (24%):

Clinical documentation did not support criteria of LCD L33797 for the following reasons:

- 7% - Signature requirements were not met
  - Medical records were not authenticated by the author
  - Medical records contain an illegible signature and no signature log or attestation statement was submitted
  - Medical records contain an illegible signature that was not validated elsewhere in the documentation submitted
- 5% - Documentation of a blood gas study performed during exercise did not meet testing criteria
  - Missing beneficiary's saturation exercising with oxygen applied
  - Missing beneficiary's saturation on room air at rest
- 3% - Replacement oxygen requirements not met
  - Missing the RA modifier and a narrative explanation of why the equipment was replaced
- 2% - No indication in the medical documentation of the presence of a severe lung disease or hypoxia-related symptoms
- 2% - Medical documentation did not demonstrate that the beneficiary was tested while in a chronic stable state
- 2% - No documentation of a titration polysomnogram for a beneficiary with obstructive sleep apnea
- 1% - Medical documentation submitted was missing pages or illegible
- 1% - No documentation of testing on 4 LPM
- 1% - Group I criteria for exercise testing was not met
  - Documentation did not support that the beneficiary's oxygen saturation was at or above 89 percent during the day while at rest

Claim Examples

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

Example 1:
DOS 6/30/14
Codes Billed: E0439

Documentation received: Initial CMN dated 6/30/14 with blood gas study results dated 6/03/15; nursing note dated 6/03/15 supporting the blood gas study results reported on the CMN; supplier forms; proof of delivery dated 6/30/14
Missing: Detailed written order signed and received prior to delivery of the items ordered; medical documentation of an in-person visit with the physician dated within 30 days prior to the initial certification date; results of a blood gas study performed within 30 days prior to the initial certification date reported on the CMN and supported in the medical documentation; signature of the beneficiary (or designee) on the proof of delivery

Example 2:
DOS 5/12/15
Codes Billed: E1390, E0431

Documentation received: Detailed written order signed 5/12/15 and documented as received on 5/12/15; initial CMN dated 5/12/15; hospital flow sheet; physical therapy note supporting the blood gas study results performed during exercise reported on the CMN; physician discharge note dated 5/12/15; proof of delivery signed by the beneficiary on 5/12/15; supplier forms
Missing: A detailed description of the E0431 on the detailed written order; evidence in the medical documentation that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy; documentation of the beneficiary's oxygen saturation at rest on room air and exercising with oxygen applied (performed within the same testing session as the test performed exercising on room air)

Example 3:
DOS 9/12/14
Codes Billed: E1390, E0431

Documentation received: Detailed written order signed on 9/10/14 and documented as received on 9/11/14; progress note dated 8/14/14 supporting the blood gas study results reported on the CMN; proof of delivery signed by the beneficiary on 9/12/14; initial CMN dated 9/12/14
Missing: A handwritten or electronic signature to authenticate the progress notes; sufficiently detailed description of the items delivered on the proof of delivery

Next Steps

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS codes E1390, E0431, and E0439.

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

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

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

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: http://www.medicarenhic.com/dme/mr.aspx

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L33797 and related Policy Article (A52514)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

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

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

- Physician Letter - Home Oxygen Initial Qualification Testing
  http://www.medicarenhic.com/dme/mobile/index.html

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

- Oxygen Highlights & Headlines
  http://www.medicarenhic.com/dme/dmeoxychanges.aspx

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

- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (posted 08/27/15, 05/29/15, 02/26/15)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/viewdoc.aspx?id=2969

- Proof of Delivery Reminder
  http://www.medicarenhic.com/viewdoc.aspx?id=2928

DMEPOS Fee Schedule DME and PEN Text File Formats (Revised)

CMS recently released revised Public Use File (PUF) formats for the CY 2016 Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) fee schedules. Revised 2016 Durable Medical Equipment (DME) and PEN text file formats are now available. Visit the Durable Medical Equipment Center webpage for more information.

https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html

Third Quarter 2015 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2015, 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	81,466	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	17,038	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	12,091	The NPI submitted is not linked to the Submitter ID under which the claim file was sent. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site and return to CEDI for processing.
X222.094.2010AA.REF02.050 Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	9,933	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.351.2400.SV101-3.040 The procedure code modifiers in SV101 must not be duplicated within the same detail service line.	8,689	The procedure code modifiers in SV101 must not be duplicated within the same detail service line.
X222.087.2010AA.NM109.030 Invalid information in the Billing Provider's NPI	8,266	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.351.2400.SV101-3.020 Procedure Modifier must be valid for the Service Date. (DTP01 = "472")	7,196	2400.SV101-3 must be valid procedure modifier on the date in 2400.DTP03 when DTP01 = "472".
X222.380.2400.DTP03.090 This Claim is rejected for Invalid Information within the Date(s) of service	7,119	The procedure code submitted for this line does not allow for spanned dates of service. Verify the start/from and end/to dates for this line are equal.
X222.380.2400.DTP03.080 This Claim is rejected for Invalid Information within the Future date and Date(s) of service	6,117	The service end/to date is greater than the date this claim was received.
X222.157.2300.CLM05-3.020 This Claim is rejected for Invalid Information within the Claim Frequency Code.	6,051	Claim Frequency Code must be "1".

Third Quarter 2015 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the third quarter of 2015. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from July through September 2015.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4, N519 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.	31,014
OA109, N418 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	13,860
CO 182, N517 Procedure modifier was invalid on the date of service	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	8,574
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.	2,607
CO 16, MA83 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).	2,145
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.	1,667
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.	1,544
CO 16, M79 Missing / incomplete / invalid charge	**Item 24F** - Did not complete or enter the appropriate charge for each listed service.	1,247
CO 16, N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	829
CO 4, MA13, MA130 The procedure code is inconsistent with the modifier used, or a required modifier is missing.	**Item 24D** - The claim contains incomplete and/or invalid information. The claim must be corrected and re-submitted.	787

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above tables and share it with your colleagues.

Supplier Manual News (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC JA) *Supplier Manual* is available via the "*Publications*" section of our website at http://www.medicarenhic.com/dme/publications.aspx. After accepting the CPT License Agreement, suppliers can access the entire *DME MAC JA Supplier Manual*, including revised chapters and archived revisions.

Updates/Corrections Made:

During the months of September, October, and November of 2015 chapters 2, 3, 6, 8, 10, 12, and Appendix A of the *DME MAC JA Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC JA) 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 website. Additionally, there are specialty/area of interest ListServes that enable DME MAC JA to send targeted information to specific supplier/provider audiences when the information is posted on our website. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DME MAC JA ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC JA Website at http://www.medicarenhic.com/dme/listserve.html

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html.
CMS encourages you to bookmark this website 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 JA) 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 JA 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.

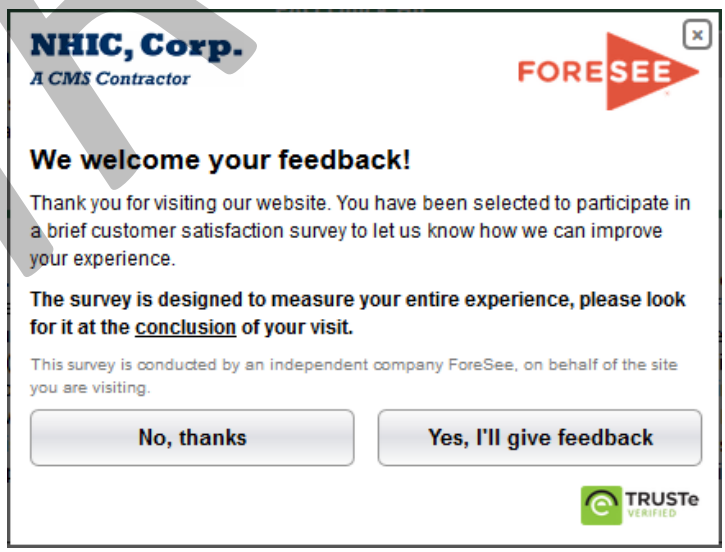
Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

NHIC, Corp. DME MAC Jurisdiction A is committed to ensuring that our website 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 JA Website 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 JA Website, 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!

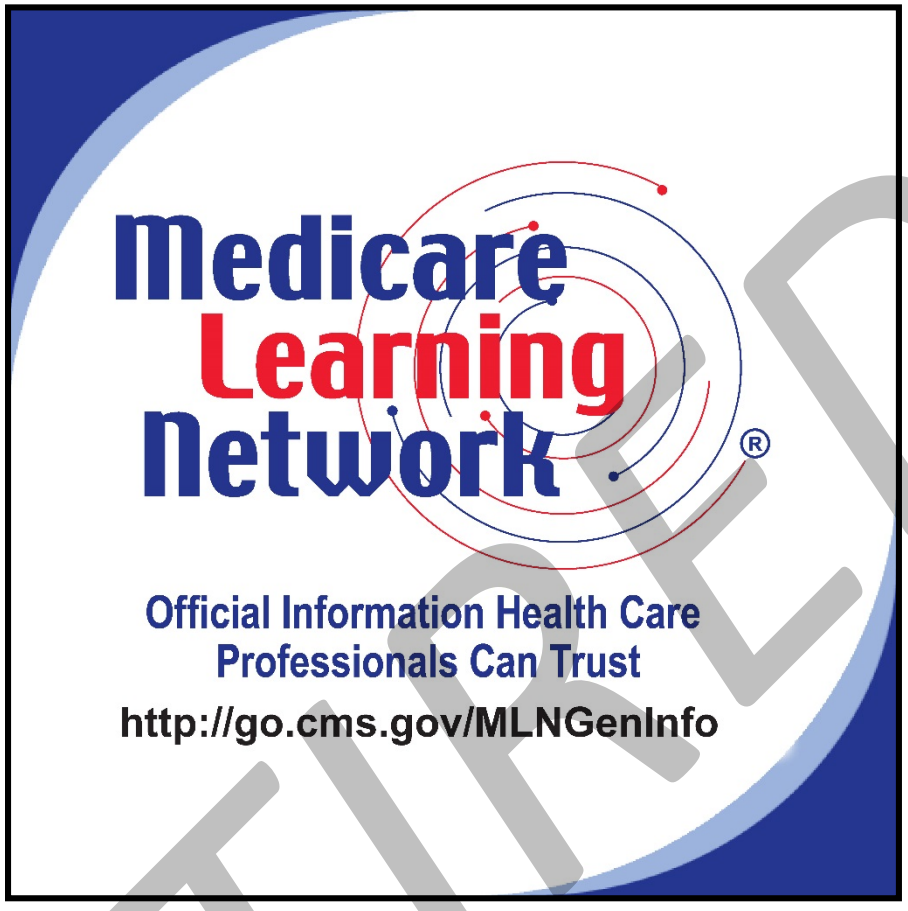
Unsolicited/Voluntary Refunds (GEN)

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

More information regarding Unsolicited/Voluntary Refunds can be found in MLN Matters Article MM3274 on the CMS Website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM3274.pdf

2016 Update to the Amount in Controversy

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2015 is $150. This amount will remain at $150 for ALJ hearing requests filed on or after January 1, 2016. The amount that must remain in controversy for review in Federal District Court requested on or before December 31, 2015 is $1,460. This amount will increase to $1,500 for appeals to Federal District Court filed on or after January 1, 2016.


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@hpe.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: 844-687-2656

Redetermination Requests Fax:

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 **or** 781-741-3842

781-741-3118 **or** 781-741-3840

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Wilfred Mamuya, MD PhD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hpe.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hpe.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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DME MAC Jurisdiction A Resource

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

December 2015
Number 38

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:

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