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

June 2015
Number 36

General Information

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

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Accreditation for Ventilators (SE1513) (SPE)

MLN Matters® Number: SE1513
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition is intended for suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for items provided to Medicare beneficiaries.

Provider Action Needed

This article alerts providers that all items in the ventilator policy group at: **https://www.dmepdac.com/resources/reports.html** are included in the DME frequent and substantial servicing payment classification for items requiring frequent and substantial servicing, and should not be confused with Positive Airway Pressure (PAP) devices such as Continuous PAP devices or Bi-level PAP devices.

The ventilator policy group includes ventilators used with both invasive and non-invasive interfaces which are classified by law as requiring frequent and substantial servicing in order to avoid risk to the patient's health. The Medicare monthly rental amount for these ventilators includes payment for the equipment and all related items and services necessary to ensure that the patient has access to equipment in good working order at all times. More information can be found at **http://www.medicarenhic.com/viewdoc.aspx?id=2653** on the Internet.

If you are a supplier who furnishes or intends to furnish ventilators, you should contact a CMS-approved accreditation organization **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizationsCMB.pdf** to ensure you meet all necessary accreditation requirements.

Background

Section 1834(a)(3) of the *Social Security Act* defines the items requiring frequent and substantial servicing and excludes PAP devices. PAP devices produce positive airway pressure used in the treatment of conditions specified in both National and Local Coverage Determinations, and are reimbursed as capped-rental items. These devices include both Continuous PAP devices and Bi-level PAP devices:

- HCPCS code E0601 - Continuous positive airway pressure (CPAP) device; and
- HCPCS code E0470 - Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g. nasal or facial mask (intermittent assist device with continuous positive airway pressure device); and
- HCPCS code E0471 - Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

To further distinguish ventilators from PAP devices, CMS is revising the descriptor language on the 855S application form **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html** for ventilators. This revision will also make clear that suppliers who furnish ventilators must meet all applicable requirements for accreditation such as ensuring that frequent and substantial servicing is provided so that the patient has access to functioning equipment at all times.

Key Points

Most suppliers who currently furnish products in the ventilator policy group to Medicare beneficiaries are already in compliance with the ventilator accreditation requirements and Appendix A of the DMEPOS Quality Standards at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf on the CMS website.

The accreditation organizations will require all suppliers who furnish HCPCS codes in the ventilator policy group to meet accreditation requirements for items classified as frequent and substantial servicing, to ensure the beneficiary has access to functioning equipment at all times. Suppliers who submit claims with dates of service on or after October 1, 2015, must be in compliance with these accreditation requirements and Appendix A of the DMEPOS Quality Standards. After this date, Medicare suppliers furnishing products in the ventilator policy group that are not in compliance must stop furnishing these items to Medicare beneficiaries until these requirements are met.

Additional Information

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

Claim Status Category and Claim Status Codes Update (MM9141) (GEN)

MLN Matters® Number: MM9141
Related CR Release Date: May 29, 2015
Related CR Transmittal #: R3272CP
Related Change Request (CR) #: CR 9141
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9141 informs MACs about the changes to the 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 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 National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/** and **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/** on the Internet.

All code changes approved during the June 2015 committee meeting shall be posted on those sites on or about July 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR9141.

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 CR9141.

Additional Information

The official instruction, CR9141, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3272CP.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.

Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014 (SE1511) (O&P)

MLN Matters® Number: SE1511
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: Not applicable
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Provider Types Affected

This MLN Matters® Special Edition (SE) is intended for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

Impact to You

Medicare currently pays for coverage of Vacuum Erection Systems (VES) prosthetic devices and related accessories, when reasonable and necessary. This article notifies suppliers of changes to the July DMEPOS Fee Schedule related to VES devices and instructs the DME MACs to implement changes to prohibit payment on claims for VES prosthetic devices (Healthcare Common Procedure Codes (HCPCS) L7900 and L7902) for dates of service on or after July 1, 2015.

What You Need to Know

Section 203 of the *Achieving a Better Life Experience (ABLE) Act of 2014* implements changes to treat VES prosthetic devices and related accessories as statutorily noncovered in the same manner that erectile dysfunction drugs are treated in Part D. Effective for claims with dates of service on or after July 1, 2015, DME MACs will deny claims submitted with HCPCS codes L7900 and L7902.

What You Need to Do

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

Background

As of July 1, 2015, HCPCS codes L7900 and L7902 codes are statutorily excluded from Medicare coverage and, therefore, are not payable when billed to Medicare. The Centers for Medicare & Medicaid Services (CMS) has issued instructions to the DME MACs to begin changes that are necessary to deny coverage for the following HCPCS codes for VES and related accessories effective for dates of service on or after July 1, 2015:

- L7900 - Male Vacuum Erection System
- L7902 - Tension Ring, for vacuum erection device, any type, replacement only, each

Pursuant to the above, DME MACs will deny such claims using Remittance Advice Remarks Code N425 (Statutorily excluded service(s).) and a Group Code of PR (Patient responsibility).

Additional Information

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under "How Does It Work" 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 (MM9138) (GEN)

MLN Matters® Number: MM9138
Related CR Release Date: May 29, 2015
Related CR Transmittal #: R3270CP

Related Change Request (CR) #: CR 9138
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9138 which instructs MACs and Medicare's Shared System Maintainers (SSMs) to update their systems based on the Council for Affordable Quality Healthcare (CAQH) 360 Uniform Use of CARC and RARC (835) Rule Set. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) Code Combination List to be published on or about June 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was under the Affordable Care Act. The *Health Insurance Portability and Accountability Act* (HIPAA) amended the Social Security by adding Part C - Administrative Simplification - to Title XI of the Social Security Act, requiring the Secretary of Health and Human Services to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The *Affordable Care Act* defines operating rules and specifies the role of operating rules in relation to the standards.

CR9138 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 June 1, 2015. This update is based on March 1, 2015 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the WPC website.

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

Note: Per the *Affordable Care Act* mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios but for the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction, CR9138
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3270CP.pdf issued to your MAC regarding this change is available 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.

July 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9159) (DRU)

MLN Matters® Number: MM9159
Related CR Release Date: May 15, 2015
Related CR Transmittal #: R3258CP

Related Change Request (CR) #: CR 9159
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

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) 9159 which instructs MACs to download and implement the July 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the April 2015, January 2015, October 2014, and July 2014 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2015, with dates of service July 1, 2015, through September 30, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The *Medicare Modernization Act of 2003* (MMA; Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "*Medicare Claims Processing Manual*" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER).
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

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

Files	Effective Dates of Service
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
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014

NOTE: *The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.*

Additional Information

The official instruction, CR9159 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3258CP.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.

July Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM9177) (GEN)

MLN Matters® Number: MM9177
Related CR Release Date: May 29, 2015

Related CR Transmittal #: R3277CP

Revised Related Change Request (CR) #: CR 9177
Effective Date: January 1, 2015 - for implementation of fee schedule amounts for codes in effect on January 1, 2015; July 1, 2015 for all other changes
Implementation Date: July 6, 2015

This article was revised on May 30, 2015, to reflect the revised CR9177 issued on May 29. In the article, the CR release date, transmittal number and the Web address for accessing the article are revised. All other information remains the same.

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

This article is based on Change Request (CR) 9177 which advises providers of the July 2015 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 staff is aware of these updates.

Background

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

Section 1834 (a), (h), and (i) of the *Social Security Act* requires payment on a fee schedule basis for 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 and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Key Points

Specific Coding and Pricing Issues

1. As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602, which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. **Claims for code A4602 that have already been processed and have dates of service on or after January 1, 2015, may not be adjusted to reflect newly established fees.**

2. Section 203 of the *Achieving a Better Life Experience (ABLE) Act of 2014* amended Section 1834(a)(1) of the *Social Security Act* to exclude Medicare coverage for vacuum erection systems.

3. As of July 1, 2015, HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:
   a. L7900 Male vacuum erection system; and
   b. L7902 Tension ring, for vacuum erection device, any type, replacement only, each

   Effective for claims with dates of service on or after July 1, 2015, claims submitted with HCPCS codes L7900 and L7902 will be denied using the following codes:
   - Group Code -PR - "Patient Responsibility."
   - Claim Adjustment Reason Codes (CARC) 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an

ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N425 - "Statutorily excluded service(s)".

Also, note that MACs will follow existing procedures for denying statutorily non-covered items, when these codes are billed with the "GY" modifier.

4. As part of the January 2015 update, fee schedules for HCPCS code A7048 (Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each) were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, CMS is providing the following clarification:
   a. HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter.
   b. A7048 is used for each single, complete collection and represents a supply allowance rather than a specifically defined kit.
   c. Items included in this code are not limited to pre-packaged kits that are bundled by manufacturers or distributors.
   d. The A7048 supplies include, but are not limited to, drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each complete drainage collection.
   e. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.

Additional Information

The official instruction, CR 9177, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3277CP.pdf** on the CMS website.

You may want to review the related MLN Matters® Article, SE1511 (*Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014*).
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1511.pdf

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?

Manual Update to Pub. 100-04, Chapter 1, to include Claims Submitted by Multiple DMEPOS Suppliers (MM9079) (GEN)

MLN Matters® Number: MM9079
Related CR Release Date: May 15, 2015
Related CR Transmittal #: R3262CP
Related Change Request (CR) #: CR 9079
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for durable medical equipment prosthetic, orthotics, and suppliers (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for supplies and services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9079, which instructs DME MACs that effective July 1, 2015, when a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary from a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim, rather than a suspect duplicate claim. Make sure that your billing staffs are aware of this change.

Background

CR 9079 informs DME MACs that manual Subsection, 120.2 D, "Claims Submitted by Multiple DMEPOS Suppliers Multiple Suppliers," has been added to Chapter 1 of the "*Medicare Claims Processing Manual*."

CR9079 Manual Update

Effective July 1, 2015, when a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary for a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim, when the following conditions are met:

- Same Beneficiary Health Insurance Claim Number (HICN);
- Overlapping span Date of Service (DOS) (From DOS and Through DOS);
- Same Healthcare Common Procedure Coding System (HCPCS) Code;
- Same Type of Service on the incoming claim matches a previously approved claim in history; and
- The item is a diabetic testing supply.

Additional Information

The official instruction, CR 9079, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3262CP.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?

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

MLN Matters® Number: SE1409
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Revised Related Change Request (CR) #: N/A
Effective Date: October 1, 2015
Implementation Date: N/A

Note: *This article was revised on May 29, 2015, to show that the April IOCE is available and that it contains ICD-9 and ICD-10 codes.*

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the *Health Insurance Portability and Accountability Act* (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

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

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

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

Provider-Initiated Beta Testing Tools

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

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at **http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html** on the CMS website;
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at **http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html** on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and *MS-DRG Definitions Manual* that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- The April 2015 version of the Integrated Outpatient Code Editor (IOCE) now includes both ICD-9-CM and ICD-10-CM. The files are available at **http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html** on the CMS website. The July 2015 IOCE release will also include both ICD-9-CM and ICD-10-CM. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2015.

Acknowledgement Testing

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

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

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

End-to-End Testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 - 30, 2015, April 27 - May 1, 2015, and July 20 - 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® article.

Claims Submission Alternatives

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

Additional Information

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

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2015 Update (MM9167) (DRU)

MLN Matters® Number: MM9167
Related CR Release Date: May 8, 2015
Related CR Transmittal #: R3254CP

Related Change Request (CR) #: CR 9167
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS Codes.

CR9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the "*Claims Processing Manual*" to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of New HCPCS Codes in CR9167

CR9167 adds the following HCPCS codes with the effective dates noted.

Table 1 - New HCPCS Codes in CR9167

Effective for Claims with Dates of Service on or after:	HCPCS Code	Long Description	Short Description	Type of Service (TOS)
March 6, 2015	Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Inj filgrastim g-csf biosim	1, P
July 1, 2015	Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron	Inj Ferric Pyrophosphate Cit	1,L
July 1, 2015	Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	Netupitant Palonosetron oral	1
July 1, 2015	Q9977	Compounded Drug, Not Otherwise Classified	Compounded Drug NOC	1, P

Note: *The Medicare Physician Fee Schedule Status Indicator for all four codes above is E.*

CR9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the "*Medicare Claims Processing Manual*" to show that, beginning in July 2015, claims for compounded drugs should be submitted using a compounded drug, NOC HCPCS code.

Additional Information

The official instruction, CR 9167 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3254CP.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) - July 2015 (MM9140) (GEN)

MLN Matters® Number: MM9140
Related CR Release Date: May 8, 2015
Related CR Transmittal #: R3256CP

Related Change Request (CR) #: CR 9140
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9140 to provide the DMEPOS Competitive Bidding Program (CBP) July 2015 quarterly update. CR9140 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are also available at **http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home** on the Internet. At that site, click on the quarterly updates link in the left of the page.

Background

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

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

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

More information is available at **http://www.dmecompetitivebid.com/palmetto/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 Re-compete, Round 2, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.

Additional Information

The official instruction, CR9140 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3256CP.pdf** on the CMS website.

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

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

Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM9192) (SPE)

MLN Matters® Number: MM9192
Related CR Release Date: May 29, 2015
Related CR Transmittal #: R3269CP

Related Change Request (CR) #: CR 9192
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed

This article, based on Change Request (CR) 9192, provides the quarterly update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of HH services. CR 9192 announces the addition of HCPCS codes 97607 and 97608, negative pressure wound therapies, to the HH consolidated billing therapy code list, effective for services on or after October 1, 2015. These codes replace codes G0456 and G0457, negative pressure wound therapies, which are deleted from the HH consolidated billing therapy code list. In addition, code A7048 replaces code A7043 on the HH Consolidated billing non-routine supply code list, effective for services on or after October 1, 2015. Be sure your staffs are aware of this update.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the HH Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA). Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS code is added to the HH consolidated billing non-routine supply code list and will replace code A7043, which is deleted from the same list effective October 1, 2015:

- A7048 - Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each.

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS codes are added to the HH consolidated billing therapy code list and will replace HCPCS codes G0456 and G0457, which are deleted from this list, effective on October 1, 2015:

- HCPCS 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters; and
- HCPCS 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

Additional Information

The official instruction, CR 9192, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3269CP.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.

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM9125) (GEN)

MLN Matters® Number: MM9125
Related CR Release Date: April 27, 2015
Related CR Transmittal #:R3242CP

Revised Related Change Request (CR) #: CR 9125
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Note: *This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below). All other information remains the same.*

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.

Provider Action Needed

This article is based on CR9125, which 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. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

Background

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

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) 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.

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. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9125, MACs will implement on the date specified on the WPC website. The WPC website is available at **http://www.wpc-edi.com/Reference** on the Internet

CR9125 lists only the changes that have been approved since the last code update CR (CR9004 issued on January 9, 2015, with a related MLN Matters® article available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.pdf**), and does not provide a complete list of codes for these two code sets. The complete list for both CARC and RARC from the WPC website is updated three times a year - around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at **http://www.wpc-edi.com/Reference** on the Internet

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

Note: *This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR once. If any modification or deactivation becomes effective at a future date, MACs must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC website.*

Changes in CARC List Since CR 9004

The following tables are changes in the CARC database since the last code update in CR 9004.

New Codes - CARC

Code	Modified Narrative	Effective Date
269	Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	03/01/2015

Modified Codes - CARC

Code	Modified Narrative	Effective Date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: 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)	03/01/2015
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	03/01/2015
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	03/01/2015
267	Claim/service spans multiple months. Rebill as separate claim/service. This change effective 9/1/2015: Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	04/01/2015

Deactivated Codes - CARC

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

Changes in RARC List Since CR 9004

The following tables are changes in the RARC database since the last code update in CR 9004.

New Codes - RARC

Code	Modified Narrative	Effective Date
N736	Incomplete/invalid Sleep Study Report.	03/01/2015
N737	Missing Sleep Study Report.	03/01/2015
N738	Incomplete/invalid Vein Study Report.	03/01/2015
N739	Missing Vein Study Report.	03/01/2015
N740	The member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service.	03/01/2015
N741	This is a site neutral payment.	03/01/2015
N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at **http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html** on the CMS website.	03/01/2015
N743	Adjusted because the services may be related to an employment accident.	03/01/2015
N744	Adjusted because the services may be related to an auto accident.	03/01/2015
N745	Missing Ambulance Report.	03/01/2015
N746	Incomplete/invalid Ambulance Report.	03/01/2015
N747	This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.	03/01/2015

Code	Modified Narrative	Effective Date
N748	Adjusted because the related hospital charges have not been received.	03/01/2015
N749	Missing Blood Gas Report.	03/01/2015
N750	Incomplete/ invalid Blood Gas Report.	03/01/2015
N751	Adjusted because the drug is covered under a Medicare Part D plan.	03/01/2015
N752	Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).	03/01/2015

Modified Codes - RARC

Code	Modified Narrative	Effective Date
N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	03/01/2015

Deactivated Codes - RARC

Code	Current Narrative	Effective Date
N483	Missing Periodontal Charts	05/01/2015
N484	Incomplete/invalid Periodontal Charts.	05/01/2015
N29	Missing documentation/orders/notes/summary/report/chart	03/01/2016
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart	03/01/2016

The full CARC and RARC lists must be downloaded from the WPC website available at http://wpc-edi.com/Reference on the Internet.

Additional Information

The official instruction, CR 9125, issued to your MAC regarding this change, is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3242CP.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.

Section 504: Implement National Medicare Summary Notices (MSNs) in Alternate Formats (MM9153) (GEN)

MLN Matters® Number: MM9153
Related CR Release Date: May 8, 2015
Related CR Transmittal #: R1499OTN

Related Change Request (CR) #: CR 9153
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9153 alerts providers that the Centers for Medicare & Medicaid Services (CMS) has designated the MACs as responsible for printing requests for large print Medicare Summary Notices (MSNs) that are sent to beneficiaries in alternate formats, and to have a third party contractor responsible for requests for Braille, CD-ROM, and Audio alternate formats. MACs are required to produce large print MSNs for beneficiaries in their respective jurisdictions who prefer large print MSNs.

Background

CMS has an obligation to provide the MSN in alternate formats for beneficiaries who elect one of the formats as a preference. CMS has been working on the alternate format project for several years. Most recently, CMS has directed MACs to provide MSNs to a subset of beneficiaries through a manual process. CR9153 implements the MAC requirements to produce large print MSNs for beneficiaries with that preference in their respective jurisdictions.

Section 504 of the *Rehabilitation Act of 1973* (Section 504), 29 U.S.C. 794 forbids Executive Agencies and recipients of Federal financial assistance from excluding individuals with disabilities or denying them an equal opportunity to receive program benefits and services.

Additional Information

The official instruction, CR9153 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1499OTN.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.

Use of Modifiers KK, KG, KU, and KW under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM9059) (GEN)

MLN Matters® Number: MM9059
Related CR Release Date: March 27, 2015
Related CR Transmittal #: R1482OTN

Revised Related Change Request (CR) #: CR 9059
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Note: *This article was revised on May 22, 2015, to reflect a revised Change Request (CR) 9059. That CR revised the remittance advice messages for adjusted claims. The transmittal number, CR release date and link to the CR also changed. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9059 to limit the use of modifiers KK, KG, KU, and KW on DMEPOS claims billed under the Competitive Bidding Program to only those uses allowed by current policy. This will reduce the number of overpayments made as a result of improper use by suppliers. Make sure your billing staffs are aware of these changes.

Background

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

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

The competitive bidding modifiers were created to identify a Healthcare Common Procedure Coding System (HCPCS) supply or accessory code that is considered both a competitive bid item and a non-competitive bid item in the same Competitive Bidding Area (CBA). Competitive bid items are identified with the appropriate modifiers in the HCPCS and pricing files available at **http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** on the Internet.

When billing for beneficiaries that reside in a CBA, suppliers should only apply modifiers KG and KK to competitive bid HCPCS codes according to current policy instructions for use of these modifiers. HCPCS codes designated as valid for use with these modifiers are listed in the Single Payment Public Use Files available at **http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** on the Internet.

Modifiers KU and KW are not currently authorized for supplier billing use and do not currently appear on the single payment file as valid for use with any DMEPOS HCPCS.

Key Point

Your DME MAC will allow claims for competitive bid items when billed with modifiers KG, KK, KU or KW only when the HCPCS/modifier combination is listed as valid on the CBIC HCPCS file. The DME MACs will return as unprocessable claims for competitive bid items when billed with modifiers KG, KK, KU or KW when the HCPCS/modifier combination is not listed as valid on the CBIC HCPCS file.

DME MACs will use the following messages when returning as unprocessable claims for competitive bid items inappropriately billed with modifiers KG, KK, KU or KW:

- Group Code CO
- CARC 4 - "The procedure code is inconsistent with the modifier used or a required modifier is missing."
- RARC MA13 - "Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code."
- RARC MA130 - "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

Note that MACs will also deny adjustment claim lines containing HCPCS inappropriately billed with modifiers KG, KK, KU, or KW.

DME MACs will use the following messages when denying adjustment claim lines containing HCPCS inappropriately billed with modifiers KG, KK, KU, or KW:

- Group Code CO
- CARC 4 - "The procedure code the modifier used or a required modifier is missing."
- RARC MA13 - "Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code."
- RARC N211 - "Alert: You may not appeal this decision."

Additional Information

The official instruction for CR9059 issued to your DME MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1482OTN.pdf** on the CMS website.

For more information regarding the appropriate use of Competitive Bidding modifiers, see Medicare Learning Network (MLN) article SE1035 titled: "*Claims Modifiers for Use in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1035.pdf** on the CMS website.

The Medicare Catalogue of Products hosts a series of DME Fact Sheets accessible at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf** on the CMS website.

If you have questions please contact your DME 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 A) Web site at: **http://www.medicarenhic.com/dme/dmfees.aspx**

This quarter the following notices have been posted:

- 2nd Quarter 2015 Oral Anticancer Drug Fees
- 2nd Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File

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

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

CMS News Flash (GEN)

New products from the Medicare Learning Network®

- "*Vaccine and Vaccine Administration Payments Under Medicare Part D*", Booklet, ICN 908764, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764.pdf**

- "*Co-Surgery Not Billed with Modifier 62*", Podcast (ICN 909209) Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/MLN-Pocast-Co-Surgery-Not-Billed-with-Modifier-62.html**

- "*The DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet*", Fact Sheet, ICN 905283, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DME_Repair_Replacement_Factsheet_ICN905283.pdf**

- "*Independent Diagnostic Testing Facility (IDTF)*", Fact Sheet, ICN 909060, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909060.html** This fact sheet is designed to provide education on requirements for the Independent Diagnostic Testing Facility (IDTF). It includes information on enrollment, the effective date of billing privileges, billing issues, ordering of tests, place of service issues and requirements for multi-state IDTFs, physicians, and technicians.

- "*The Medicare Home Health Benefit*" Web-Based Training Course (WBT) was released and is now available. This WBT is designed to provide education on Medicare home health services. It includes information on qualifying for home health services, consolidated billing, therapy services, and billing and payment. Continuing education credits are available to learners who successfully complete this course. See course description for more information. To access the WBT, go to MLN Products (**http://www.cms.gov/MLNProducts**), scroll to the bottom of the web page and under "Related Links" click on "Web-Based Training Courses."

- "*The Medicare Home Health Benefit*", Fact Sheet, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-Benefit-Fact-Sheet-ICN908143.pdf**

REVISED products from the Medicare Learning Network®

- "Resources For Medicare Beneficiaries", Fact Sheet, ICN 905183, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf**

- "*Items and Services That Are Not Covered Under the Medicare Program*", Booklet (ICN: 906765) **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf**

Electronic Mailing List for Referral Agents

An electronic mailing list is available 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, the Centers for Medicare & Medicaid Services (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" subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!
https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814

MLN Matters® Articles Index

Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/** on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

Coding for ICD-10-CM: More of the Basics MLN Connects™ Video

In this MLN Connects™ video on Coding for ICD-10-CM: More of the Basics
https://www.youtube.com/watch?v=s86pXhhOG7c&list=UUhHTRPxz8awulGaTMh3SAkA
Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. Run time: 36 minutes.

MLN Connects® Provider eNews (GEN)

MLN Connects® Provider eNews for March 12, 2015

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

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-03-12-eNews.pdf

MLN Connects® National Provider Calls

- Physician Quality Reporting Programs: Reporting Once in 2015 - Last Chance to Register
- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 - Registration Now Open
- Medicare Shared Savings Program ACO: Application Process - Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting
- Webinar for Comparative Billing Report on Modifier 25: Nurse Practitioners

Announcements

- Affordable Care Act Initiative Builds on Success of ACOs
- Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline
- New ST PEPPER Available
- Medicare EHR Incentive Program: Hardship Exceptions for Hospitals due April 1
- EHR Incentive Program: Part B Drugs and Payment Adjustments

Claims, Pricers, and Codes

- April 2015 Average Sales Price Files Now Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2014 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)" MLN Matters® Article - Released
- "Global Surgery" Fact Sheet - Revised
- "Guidelines for Teaching Physicians, Interns, and Residents" Fact Sheet - Revised
- "Mental Health Services" Booklet - Revised
- "Medicare Vision Services" Fact Sheet - Reminder
- "HIPAA Privacy and Security Basics for Providers" Fact Sheet - Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects® Provider eNews for March 19, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-03-19-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-03-19-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 - Register Now
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data - Registration Opening Soon
- Medicare Shared Savings Program ACO: Application Process - Register Now

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July - Forms Due April 17
- eHealth Webinar: eCQM 101 on Quality Reporting Programs
- Medicare Basics for New Providers Webinar - Registration Now Open

Announcements

- Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources
- RAs from January 2015 ICD-10 End-to-End Testing
- Bidding for Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program Closes March 25
- March is National Colorectal Cancer Awareness Month-Encourage Your Patients to Get Screened
- March is Save Your Vision Month
- Flu on the Decline but Still Active
- EHR Incentive Program: Eligible Professionals Attest for 2014 Participation by March 20
- CMS Extends Letter of Intent Deadlines for the Oncology Care Model
- Obtaining Your Quality and Resource Use Report: Updated Information Available
- CMS to Release Ophthalmology Comparative Billing Report in April
- Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline

Claims, Pricers, and Codes

- Mandatory Payment Adjustment Percentage of 2% Extended for Medicare FFS Claims (Sequestration)
- Correcting the Display Issue for OPPS Claims Where Value Code "FD" Is Present
- Mass Adjustment of Claims Containing Codes G0473 and 77063

Medicare Learning Network® Educational Products

- March 2015 Version of The Medicare Learning Network® Catalog - Released

MLN Connects® Provider eNews for March 26, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-03-26-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-03-26-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 - Register Now
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data - Registration Now Open
- How to Register for the PQRS Group Practice Reporting Option in 2015 - Registration Now Open
- Medicare Shared Savings Program ACO: Application Process - Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July - Forms Due April 17
- Medicare Basics for New Providers Webinar - Register Now

Announcements

- DOJ and HHS Announce over $27.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud
- HHS Announces Proposed Rules to Support the Path to Nationwide Interoperability
- Star Ratings for Home Health Compare: Provider Preview Reports Available in Late March
- Medicare EHR Incentive Program Hospitals: Apply for Hardship Exception by April 1

Claims, Pricers, and Codes

- New RARC Alerts Providers about Upcoming Transition to ICD-10
- Updates to IRIS Software
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network ® Educational Products

- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet - Reminder
- "Internet-based PECOS FAQs" Fact Sheet - Reminder
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for April 2, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-04-02-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-04-02-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 - Last Chance to Register
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data - Register Now
- How to Register for the PQRS Group Practice Reporting Option in 2015 - Register Now
- Medicare Shared Savings Program ACO: Application Process - Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July - Forms Due April 17

Announcements

- Screening and Counseling to Reduce Alcohol Misuse
- Newly Approved Drugs and Biologicals
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Register for the Health Care Payment Learning and Action Network
- Quarterly Provider Update for April 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set
- Partial Hospitalization Program Claims Coding and Payment Rates for CY 2015
- New RARC Alerts Providers about Upcoming Transition to ICD-10

Medicare Learning Network® Educational Products

- "Preventive Services" Educational Tool - Revised
- "Long Term Care Hospital Prospective Payment System" Fact Sheet - Revised
- "Clinical Laboratory Fee Schedule" Fact Sheet - Revised
- "Medicare Appeals Process" Fact Sheet - Reminder
- "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Fact Sheet - Reminder
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for April 9, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-04-09-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-04-09-eNews.pdf

MLN Connects® National Provider Calls

- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data - Last Chance to Register
- How to Register for the PQRS Group Practice Reporting Option in 2015 - Last Chance to Register
- Medicare Shared Savings Program ACO: Application Process - Register Now

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July - Forms Due April 17
- Webinar for Comparative Billing Report on Ophthalmology

Announcements

- Results From March 2015 ICD-10 Acknowledgement Testing Week
- Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources
- 2015 PV-PQRS GPRO Registration is Now Open
- Open Payments Physician and Teaching Hospital Review and Dispute Period Began April 6
- EHR Stage 3 Proposed Rule: Comment Period Closes May 29
- Medscape Article for CME Credit: Public Reporting on Quality and Payments

Claims, Pricers, and Codes

- Mass Adjustment of OPPS Claims with APC 1448
- April 2015 Outpatient Prospective Payment System Pricer File Update
- January 2015 PPS Provider Data Available - Revised

Medicare Learning Network® Educational Products

- "Food and Drug Administration Approval of First Biosimilar Product" MLN Matters® Article -Released
- "Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014" MLN Matters® Article - Released
- "Partial Hospitalization Program (PHP) Claims Coding & CY2015 per Diem Payment Rates" MLN Matters® Article - Released
- "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants" Booklet - Revised
- "The ABCs of the Initial Preventive Physical Examination (IPPE)" Educational Tool - Revised
- "The ABCs of the Annual Wellness Visit (AWV)" Educational Tool - Revised

MLN Connects® Provider eNews for April 16, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-04-16-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-04-16-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Application Process - Last Chance to Register

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July - Forms Due April 17

Announcements

- April is Sexually Transmitted Infections Month
- Is Your National Association an MLN Connects® Partner?
- LTCH Quality Reporting Program Data Submission Deadline: May 15
- IRF Quality Reporting Program Data Submission Deadline: May 15
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Proposed Rule Outlines EHR Requirements for Providers for 2015 through 2017

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 3]" Educational Tool - Released
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for April 23, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-04-23-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-04-23-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs - Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

Announcements

- Proposed FY 2016 Skilled Nursing Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient and Long-Term Care Hospital Payment and Policy Changes
- DMEPOS Competitive Bidding Round 1 2017 Announced
- National Minority Health Month

- CMS Releases Hospital Compare Star Ratings
- New Hospice Reports Available in CASPER
- CMS to Release Transthoracic Echocardiography Comparative Billing Report in May
- CMS to Award Special Innovation Projects for Partnership-Driven Quality Improvement Projects
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Coordination of Benefits Issue Impacting Outpatient Hospital Claims
- Updated: Correcting the Display Issue for OPPS Claims Where Value Code "FD" Is Present

Medicare Learning Network® Educational Products

- "Independent Diagnostic Testing Facilities" Podcast - Released
- "Vaccine and Vaccine Administration Payments under Medicare Part D" Fact Sheet - Revised
- "Home Health Prospective Payment System" Fact Sheet - Revised
- "Medicare Fraud and Abuse: Prevention, Detection, and Reporting" Web-Based Training Course - Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact

MLN Connects® Provider eNews for April 30, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-04-30-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-04-30-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs - Register Now
- 2014 Mid-Year QRURs - Save the Date
- New MLN Connects® National Provider Call Video Slideshow, Audio Recordings and Transcripts

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Patient Survey Star Ratings

Announcements

- Proposed FY 2016 Inpatient Rehabilitation Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient Psychiatric Facility Payment and Policy Changes
- Focusing on Women's Health
- Open Payments Physician and Teaching Hospital Review and Dispute Period Ends May 20
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PV-PQRS GPRO Registration is Open
- Participation Continues to Rise in Medicare PQRS and eRx Incentive Program
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Five Facts about ICD-10
- 2014 Mid-Year QRURs Available

Claims, Pricers, and Codes

- April 2015 Outpatient Prospective Payment System Pricer File Update
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality

Medicare Learning Network® Educational Products

- "Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims" MLN Matters® Article - Released
- "Accreditation for Ventilators" MLN Matters® Article - Released

- "The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Repairs and Replacements" Fact Sheet - Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects® Provider eNews for May 07, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-05-07-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-05-07-enews.pdf

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs for Hospitals - Last Chance to Register
- 2014 Mid-Year QRURs - Registration Now Open
- National Partnership to Improve Dementia Care and QAPI - Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July - Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Webinar for Comparative Billing Report on Transthoracic Echocardiography

Announcements

- Proposed Updates to Hospice Wage Index and Payment Rates
- May is National Osteoporosis Month
- Medicare Coverage for Viral Hepatitis
- New CDC Measles Information and Resources
- HHS Announces $101 Million in Affordable Care Act Funding to 164 New Community Health Centers
- Amendment to Disproportionate Share Hospital Ruling
- Inpatient Hospital Probe and Educate Extension
- Quality Reporting Programs: Updated 2014 eCQMs for 2016 Reporting
- CMS Announces the Physician Quality Reporting Programs Strategic Vision
- ICD-10 Resources for Medicare Providers
- Five More Facts about ICD-10
- Medscape Article for CME Credit: Improving Quality of Care through Care Coordination
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- FY 2016 Inpatient and LTCH PPS Proposed Rule: Comment Period Ends June 16
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "The Medicare Home Health Benefit" Web-Based Training Course - Released
- "Resources for Medicare Beneficiaries" Fact Sheet - Revised
- "Medicare Part B Immunization Billing" Educational Tool - Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects® Provider eNews for May 14, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-05-14-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-05-14-eNews.pdf

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs - Register Now
- Medicare Shared Savings Program ACO: Application Review - Registration Now Open
- National Partnership to Improve Dementia Care and QAPI - Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 - Save the Date
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Register Now

MLN Connects® Videos

- New ICD-10 Videos: Impact on Inpatient Hospital Payment and Medicare Testing Plans

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July - Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

Announcements

- Depression is Not a Normal Part of Growing Older
- Therapy Caps Exceptions Process Extended through CY 2017
- Questions about Medicare?
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Groups: 6 Weeks Left to Register for 2015 PQRS GPRO

Medicare Learning Network® Educational Products

- "Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model" MLN Matters® Article - Released
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet - Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for May 21, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-05-21-eNews.html

View this edition as a PDF

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-05-21-eNews.pdf

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs - Register Now
- Medicare Shared Savings Program ACO: Application Review - Register Now
- National Partnership to Improve Dementia Care and QAPI - Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 - Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Register Now

MLN Connects® Videos

- New Video on PQRS and the Value-Based Payment Modifier

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July - Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5

Announcements

- 2014 Mid-Year QRURs Available
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- Call for TEP Nominations: Closing Date June 1
- CMS to Release Comparative Billing Report on CT Scans of the Abdomen and Pelvis in June

- EHR Incentive Program: Deadline for Eligible Professional Hardship Exception is July 1
- PQRS: IACS Transitioning to EIDM on July 13
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)" MLN Matters® Article - Released
- "Power Mobility Pearls for the Practicing Physician" Web-Based Training Course - Released
- "Clarification of the Use of Modifiers When Billing Wrong Surgery on a Patient" Podcast - Released
- "Co-Surgery Not Billed with Modifier 62" Podcast - Released
- "Chronic Care Management Services" Fact Sheet - Reminder
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network Product® Available In Electronic Publication Format

MLN Connects® Provider eNews for May 28, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-05-28-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-05-28-eNews.pdf

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs - Last Chance to Register
- Medicare Shared Savings Program ACO: Application Review - Register Now
- National Partnership to Improve Dementia Care and QAPI - Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 - Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Register Now
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data - Registration Now Open
- ESRD QIP: Proposed Rule for Payment Year 2019 - Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Quality Reporting Requirements
- Physician Compare Virtual Office Hour Session
- EHR Proposed Rules: Recordings and Presentations from Webinars

Announcements

- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PQRS GPRO: 4 Weeks Left to Register by June 30 Deadline
- HHS Awards $112 Million to Help 5,000 Primary Care Professionals Advance Heart Health
- Guidance on Beneficiary Disenrollments by Long Term Care Facilities

Claims, Pricers, and Codes

- ICD-10 FAQs: CMNs and Prescriptions
- Transition to ICD-10 for Home Health
- April 2015 IOCE Updated with ICD-10-CM Codes
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Mass Adjustment of FQHC PPS Claims

Medicare Learning Network® Educational Products

- "Medically Unlikely Edits Compliant" Podcast - Released
- "Electronic Prescribing (eRx) Incentive Program - A Compilation of 2013 Educational Resources" Booklet - Released
- "Medicare Appeals Process" Fact Sheet - Revised

MLN Connects® Provider eNews for June 04, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-04-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-06-04-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Application Review - Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI - Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 - Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Register Now
- Hospital Compare Overall Star Ratings Methodology - Save the Date
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data - Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 - Register Now

MLN Connects® Videos

- Prepare for ICD-10 with MLN Connects® Videos

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week through June 5
- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis

Announcements

- New Affordable Care Act Payment Model Seeks to Reduce Cardiovascular Disease
- New Medicare Data Available to Increase Transparency on Hospital and Physician Utilization
- Entrepreneurs and Innovators to Access Medicare Data
- DMEPOS Competitive Bidding Round 1 2017 - Get Licensed
- Quality Reporting Programs: 2014 eCQM Updates for 2016 Reporting

Claims, Pricers, and Codes

- July 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- "Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice of Noncoverage (ABN)" Web-Based Training Course - Released
- "Anesthesiologist Services with a Modifier GC in a Method II Critical Access Hospital (CAH)" Podcast - Released
- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets" Educational Tool - Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet - Revised

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

Decision Desktop Implementation

NHIC is pleased to announce the implementation of *Decision Desktop*. *Decision Desktop* is a new self-service option which will allow suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. The *Decision Desktop* tool allows a supplier to enter a Claim Control Number (CCN) for a claim that has undergone Complex Medical Review and see the claim decision and a detailed reason for a claim denial in real time. This tool will enable supplier's direct access to additional details relating to the reason for denial and save supplier's time since it will no longer be necessary to contact Customer Care for this level of detail

Instructions for Use: The *Decision Desktop* tool can be accessed at: **http://www.medicarenhic.com/dme/mr.aspx**
Enter the 14-digit CCN in the CCN form field and select Submit.

Note: *If you disagree with the medical review denial; the claim can be submitted to the first level of appeal, redetermination. Be sure to include all documentation to support the medical need for the item being provided as required by the medical policy.*

For additional information on the redetermination process refer to:
http://www.medicarenhic.com/dme/billingappeals.aspx#appeals3

Coverage and Coding - New Oral Antiemetic Drug Akynzeo® - Revised - Joint DME MAC Publication (DRU)

The U.S. Food and Drug Administration approved Akynzeo® on October 10, 2014. Akynzeo® is a combination medication used to treat nausea and vomiting in patients undergoing cancer chemotherapy.

Akynzeo® is a fixed combination capsule comprised of two drugs, oral palonosetron (a $5HT_3$ antagonist) and netupitant (a NK-1 antagonist). The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Akynzeo® and determined that it is eligible for inclusion in the DME MAC Oral Antiemetic Drug (Replacement for Intravenous Antiemetics) Local Coverage Determination (LCD), effective for claims with dates of service on or after October 10, 2014.

The use of the oral anti-emetic 3-drug combination of an FDA-approved oral NK-1 antagonist and an oral $5HT_3$ 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 prior to July 1, 2015, claims for Akynzeo® 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

For dates of service on or after to July 1, 2015, claims for Akynzeo® must be billed using HCPCS code:

Q9978 NETUPITANT PALONOSETRON ORAL NETUPITANT 300 MG AND PALONOSETRON 0.5 MG, ORAL

Akynzeo® (Q0181 or Q9978) must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage. There must be no unbundling of the netupitant and palonosetron combination in Akynzeo®.

If Akynzeo® (Q0181 or Q9978) 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.

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 Akynzeo® (Q0181 or Q9978) 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. 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 Anti-emetic Drug (Replacement for Intravenous Antiemetics) Local Coverage Determination and related Policy Article for further information on coverage, documentation and coding.

Billing Instruction - Blinatumomab (Blincyto™) - DME MAC Joint Publication (DRU)

Medicare encourages physicians, hospitals, other providers and suppliers to administer medication to patients in such a way that they use the drugs most efficiently, and in a clinically appropriate manner.

The dose or quantity of medication necessary to administer the prescribed amount is covered based upon the payment rules in the applicable medical policy. When the remainder of a single use vial or other single use package must be discarded after administering a dose of the drug to a Medicare patient, the program provides payment for the amount discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Blinatumomab was recently approved for use by the Food and Drug Administration, and has been included in the DME MAC External Infusion Pump LCD as a covered drug for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. Coverage is effective for claims with dates of service on or after December 03, 2014.

Blinatumomab is supplied in 35 mcg (lyophilized powder) single-use vials. The drug is reconstituted with sterile water in a USP <797> compliant facility, and placed in a bag coated with an IV Solution Stabilizer, which can be subsequently refrigerated (2°C to 8°C) for up to eight-days. A reconstituted bag contains 56 mcg, which is infused over 48 hours.

One unit of service (UOS) equals one (1) vial, and each UOS must be prepared using the combination of vials that result in the least amount of wastage for the dosage amount being administered. Five vials should be used to reconstitute three bags, each containing 56 mcg of blinatumomab, which can be refrigerated and used within six-days, leading to the least amount of wastage.

Using this method, usual utilization is 25 vials per month. Claims that exceed 25 UOS per month will be denied as not reasonable and necessary.

Please refer to the External Infusion Pump LCD and related Policy Article for additional coverage, coding and documentation requirements.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding contractor (PDAC) at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form at: **https://www.dmepdac.com/contact/index.html**

Correct Coding - BEMER Physical Vascular Therapy Devices - DME MAC Joint Publication (GEN)

BEMER Physical Vascular Therapy Devices (BEMER International AG) provides broad spectrum, low intensity, pulsed, electromagnetic therapy which the manufacturer claims is effective for various conditions. This technology comes in differing configurations (Classic, Pro) and with a variety of accessories.

Questions for this device and related accessories should be directed to the Medicare Part B Carrier.

There is no DME HCPCS code assigned for these items that is valid for claim submission to the DME MACs. Consult with the Part B Contractor for coding and coverage guidance.

Claims submitted to the DME MACs for these items using Not Otherwise Classified (NOC) codes will be denied as wrong jurisdiction.

Claims submitted to the DME MACs for these items using existing "E" series HCPCS codes for electrical or electromagnetic devices such as TENS, neuromuscular stimulator, wound healing devices, joint stimulation devices etc. (not all-inclusive) will be denied as incorrect coding.

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

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

As part of the 2014 and 2015 HCPCS update, codes were created describing certain off-the-shelf (OTS) orthotics. Some of these codes parallel codes for custom fitted versions of the same items. Refer to the table at the end of this article for a listing of codes.

When providing these items suppliers must:

- Provide the product that is specified by the ordering physician
- Be sure that the ordering physician's medical record justifies the need for the type of product (i.e., Prefabricated versus Custom Fabricated)
- Only bill for the HCPCS code that accurately reflects both the type of orthosis and the appropriate level of fitting.
- Have detailed documentation in the supplier's record that justifies the code selected

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

Off-the-shelf (OTS) orthotics are:

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

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

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as OTS if the final fitting upon delivery to the patient requires minimal self-adjustment as described in this section.

Custom fitted orthotics are:

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

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

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

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

Kits are:

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

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

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

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

Classification Algorithm - Overview of Criteria

Determining Proper Coding of Prefabricated Orthotics

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

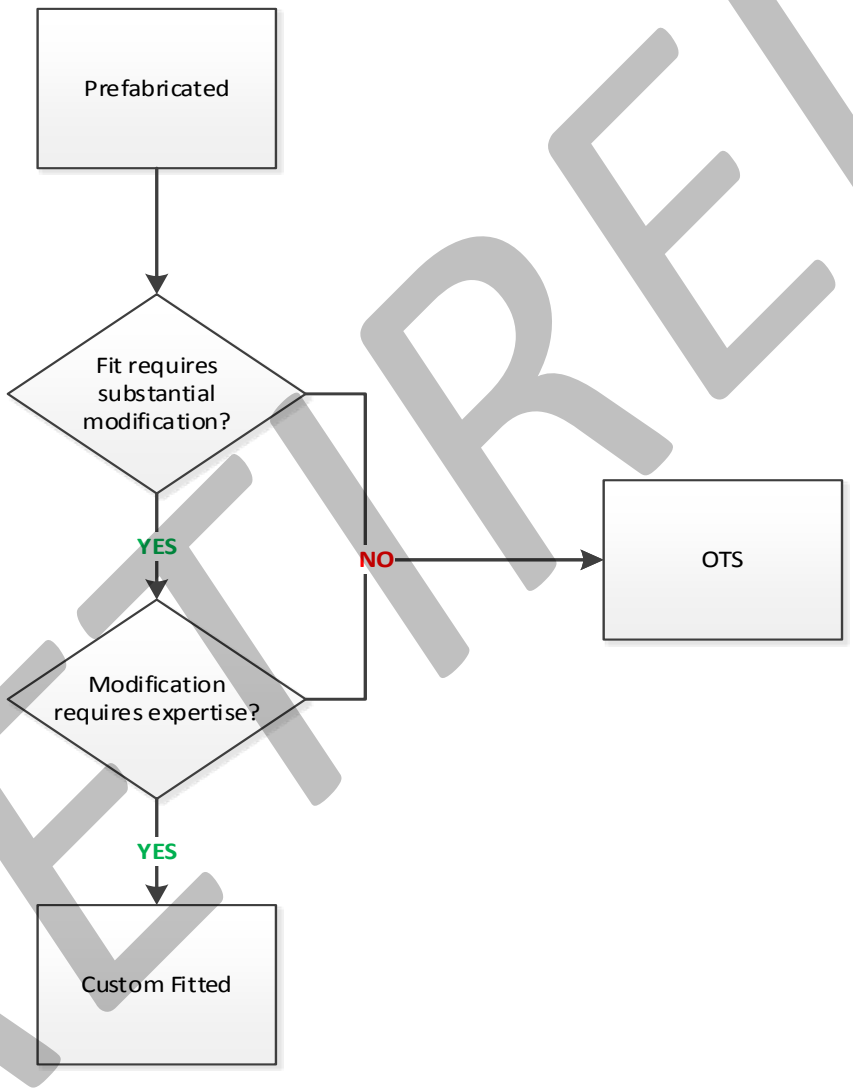
- Off-the-shelf (OTS) - Prefabricated item that requires minimal self-adjustment such as being trimmed, bent, molded, assembled, or otherwise adjusted to fit the beneficiary. Minimal self-adjustment does not require the expertise of a certified orthotist or an individual with equivalent expertise.

- Custom fitted - Prefabricated item that requires substantial modification e.g., has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by certified orthotist or an individual with equivalent expertise.

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

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

How to Decide What Code Type for Prefabricated Orthotic



2015 HCPCS New Code Table

Note 1: Some Custom Fitted codes do not have corresponding OTS codes. If items described by these codes are furnished off-the-shelf without custom fitting or with fitting performed by someone without expertise in fitting, the corresponding code for the broader category of orthotics not otherwise specified in the HCPCS (e.g., L1499 for Spinal Orthosis, Not Otherwise Specified) should be used. The supplier should indicate in the narrative field for the claim that the orthotic was furnished off-the-shelf.

Note 2: Not all new codes listed have a corresponding medical policy. There are policies for Ankle/Foot and Knee/Ankle/Foot Orthosis, Knee Orthosis and Spinal Orthosis. There are no medical policies for Hip, Wrist, Hand, Finger or Shoulder Orthosis

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L0454	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0455	TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0456	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0457	TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, THORACIC REGION, RIGID POSTERIOR PANEL AND SOFT ANTERIOR APRON, EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
L0460	TLSO, TRIPLANAR CONTROL, MODULAR SEGMENTED SPINAL SYSTEM, TWO RIGID PLASTIC SHELLS, POSTERIOR EXTENDS FROM THE SACROCOCCYGEAL JUNCTION AND TERMINATES JUST INFERIOR TO THE SCAPULAR SPINE, ANTERIOR EXTENDS FROM THE SYMPHYSIS PUBIS TO THE STERNAL NOTCH, SOFT LINER, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL, CORONAL, AND TRANSVERSE PLANES, LATERAL STRENGTH IS PROVIDED BY OVERLAPPING PLASTIC AND STABILIZING CLOSURES, INCLUDES STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE		No Corresponding Code
L0466	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0467	TLSO, SAGITTAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0469	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0641	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES,VERTEBRA, PRODUCES INTRACAVITARY MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0642	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES,VERTEBRA, PRODUCES INTRACAVITARY MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0643	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0648	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0649	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0650	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0651	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE		No Corresponding Code
L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTI		No Corresponding Code
L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTSE		No Corresponding Code
L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L1812	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, OFF-THE-SHELF
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L1833	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, OFF-THE SHELF

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	K0901	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	K0902	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L1848	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, OFF-THE-SHELF
L3677	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3678	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, OFF-THE-SHELF, ANY TYPE
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3916	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3918	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED, OFF-THE-SHELF
L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3924	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3930	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, OFF-THE-SHELF

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L4361	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L4387	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, OFF-THE-SHELF

Correct Coding - LIM innovations Infinite Socket™ - DME MAC Joint Publication (O&P)

LIM innovations Infinite Socket™ TF C1 is a prefabricated modular above-knee design that has recently become available. This product uses four struts that extend from the base to an adjustable brim to form the structure of the item.

The existing HCPCS L-codes used for above-knee lower limb prosthesis sockets describe items which enclose the residual limb to provide the stability, proprioception, and suspension necessary for the effective use of the artificial limb. This product is sufficiently different in design and construction that existing L-codes for sockets and socket additions are inappropriate for use with this product. Claims for this item using existing L-codes will be denied as incorrect coding.

As a defined-benefit program, the first requirement for any item to be potentially eligible for Medicare reimbursement is that the item must qualify for inclusion into an existing benefit category. There is no evidence in the clinical literature demonstrating that this design is able to function effectively as a socket for a lower limb prosthesis. Therefore, the item does not qualify for inclusion in the Artificial Limbs benefit category. The correct code to use for Medicare claims for this item is:

A9270 NONCOVERED ITEM OR SERVICE

This coding determination is all-inclusive. Separate billing for options, accessories, additions, etc. used with this product will be denied as unbundling.

Refer to the Lower Limb Prosthesis Local Coverage Determination and related Policy Article for additional information on coverage, coding and documentation for artificial limbs.

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

Correct Coding - Urinary "No-Touch" Catheters - DME MAC Joint Publication (SPE)

Urinary "no-touch" catheter systems are designed to perform urinary catheterization without the need to directly touch the catheter during insertion. The Urologic Supplies Local Coverage Determination (LCD) provides coverage for these products as either a single-use intermittent catheter (A4351, A4352) or as a sterile kit (A4353) depending upon the configuration of the specific product. The narratives for these HCPCS codes are:

A4351 INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH

A4352 INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH

A4353 INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES

In order to be correctly coded as A4353 the no-touch catheter must meet all of the requirements specified in the CODING GUIDELINES section of the Urologic Supplies related Policy Article. The guideline for A4353 says:

An intermittent urinary catheter with insertion supplies (A4353) is a kit, which includes a catheter and all supplies necessary for a single, sterile insertion (see below). Code A4353 may be used if any of the following 1, 2, or 3 is supplied:

1. A single sterile package containing both an intermittent urinary catheter and all necessary insertion/collection supplies: or
2. A sterile intermittent urinary catheter plus a separately-packaged sterile kit containing all necessary insertion/collection supplies; or,
3. **A sterile "no-touch" type of catheter system.**

The insertion kit (A4353) described in #1 and #2 above contains an intermittent urinary catheter (packaged separately from the other components in #2), lubricant, gloves, antiseptic solution, applicators, a drape, and a collection tray/bag in a sterile package intended for single use. The collection tray/bag is a separate item included within the kit; therefore, materials that serve as non-sterile packaging to contain all of the items in the kit do not meet this requirement. Except as noted in #2 above, code A4353 must not be billed if individual insertion kit components are provided as separate items. When providing a sterile kit, all components are included and packaged as a kit. Separate billing of individual components is considered as unbundling.

The product described in #3 is a single-catheter system that is functionally equivalent to a complete sterile insertion kit (A4353) containing a catheter and the additional components as described in the previous paragraph. In order to be coded as A4353, a "no-touch" type of catheter system must be a sterile, all-inclusive, self-contained system capable of accomplishing intermittent catheterization with sterile technique without the use of additional supplies such as gloves, lubricant, collection chamber, etc. Additional individual components must not be separately billed. Separate billing of additional supply items is considered as unbundling. (Emphasis added)

Only those "no-touch" systems that are the complete functional equivalent of a standard sterile kit, including the presence of a collection chamber, are eligible to be coded as A4353. The collection chamber may be an integral part of the catheter or may be a separate item provided as part of the complete system. Systems that do not have a collection chamber or otherwise are not functionally equivalent in performing a sterile-technique catheter insertion must be coded as an intermittent catheter, A4351 or A4352, depending upon the catheter configuration.

Refer to the Urologic Supplies LCD and related Policy Article for additional information about coverage, documentation and coding.

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

Correct Coding - Weightless Walker - DME MAC Joint Publication (MOB)

The Weightless Walker (Weightless Walker, Inc.) is an enclosed, wheeled walker with a seat. The correct HCPCS code for billing this item to Medicare is:

E0144 - WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT

Refer to the Walkers LCD and related Policy Article for information about coverage and documentation.

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

Correct Coding - WHILL Model A Powered Personal Mobility Device - DME MAC Joint Publication (MOB)

The WHILL Model A (Whill, Inc., San Carlos, CA) is a powered personal mobility device designed "…to improve the mobility for all, not just those with a disability." As noted by the manufacturer, this product has not been submitted to the FDA and is not considered to be a medical device. Consequently, this item is non-covered (no Medicare benefit).

For Medicare billing purposes, claims for this device must be submitted using HCPCS code:

A9270 - NONCOVERED ITEM OR SERVICE

This code is considered as all-inclusive for this product. None of the existing HCPCS codes for wheelchair bases, options, accessories, seating, etc. are appropriate for use with this product. Claims for this item using existing wheelchair related codes will be denied as incorrect coding.

DMEPOS Suppliers are reminded that there is no Medicare reimbursement available for repairs or replacement of non-covered items.

Refer to the Power Mobility Devices, Wheelchair Options and Accessories and Wheelchair Seating LCDs and related Policy Articles for additional information on coverage, coding and documentation requirements.

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

Vacuum Erection Devices - Non-Covered by Medicare - Joint DME MAC Publication (O&P)

The *Achieving a Better Life Experience (ABLE) Act of 2014* eliminated Medicare coverage for vacuum erection devices (VED). Consequently, claims billed to Medicare for codes L7900 and L7902 for dates of service on or after July 1, 2015 will be denied as non-covered (no benefit).

The DME MAC Vacuum Erection Devices (VED) Local Coverage Determination and Related Policy Article will be revised to reflect this change in coverage, effective for dates of service on or after July 1, 2015.

LCD and Policy Article Revisions Summary for March 12, 2015 (GEN)

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

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

- Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

- Added: Standard Documentation Language for Dispensing Orders
- Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
- Added: Instructions for Equipment Retained from a Prior Payer
- Added: Repair/Replacement section
- Removed: ICD-9 CM reference

Policy Article

Revision Effective Date: 01/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added: HCPCS Code A9272 (code effective 01/01/2012) to statement regarding denial of disposable wound suction pumps and related supplies

CODING GUIDELINES:

- Added: Instructions for billing disposable wound suction system
- Revised: Instructions for billing supplies used with disposable wound suction systems

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

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

- Revised: Standard Language
- Added: Language from RAD LCD allowing Sleep study Types II, III, IV testing in facility setting

DOCUMENTATION REQUIREMENTS:

- Revised: Standard Language

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added: Standard language reference to benefit category citation in Social Security Act.
- Added: Statutory denial for liners
- Revised: Face-to-Face Standard Language

CODING GUIDELINES:

- Added: Correct coding of liners
- Added: Correct coding of monitoring technology

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

LCD and Policy Article Revisions Summary for March 19, 2015 (GEN)

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

Heating Pads and Heat Lamps

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language regarding Medicare coverage

DOCUMENTATION REQUIREMENTS:

Added: Instructions for Refill Documentation

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Revised: Moved Continued Need above Continued Use documentation

Added: Equipment Retained from a Prior Payer

Added: Instructions for Repair Replacement to beneficiary-owned DMEPOS

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

Removed: Refill Requirements

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Removed: Request for refill documentation requirements

Added: Instructions for Equipment Retained from a Prior Payer

Added: Instructions for Repair Replacement

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

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

LCD and Policy Article Revisions Summary for March 26, 2015 (GEN)

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

Canes and Crutches

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

Cold Therapy

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility Standard Documentation Language

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2015 (March 2015 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Maximum utilization for Blinatumomab; inadvertently omitted
DOCUMENTATION REQUIREMENTS:
Revised: Instructions for Revised DIF
Added: Instructions for Recertification DIF

Policy Article

Revision Effective Date: 01/01/2015 (March 2015 Publication)
CODING GUIDELINES:
Revised: Units of service for blinatumomab
Added: Instructions for least wastage of blinatumomab; inadvertently omitted from previous publication

Infrared Heating Pad System

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Added Appendices verbiage

Manual Wheelchair Bases

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Refill Documentation
Added: Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES
Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

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

LCD and Policy Article Revisions Summary for April 2, 2015 (GEN)

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

Commodes

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:

Deleted: Reference to refill of supplies from Continued Use
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS

Immunosuppressive Drugs

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: ICD-9 CM reference

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: ICD-9 diagnosis references
CODING GUIDELINES:
Revised: J7599 billing guidelines

Intrapulmonary Percussive Ventilation System

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: PIM citation reference under Appendices

Oral Appliances for Obstructive Sleep Apnea

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Continued Medical Need/Continued Use sections
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Added: Repair/Replacement section
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Diagnosis code reference

Policy Article

Revision Effective Date: 01/01/2015
CODING GUIDELINES:
Revised: Coding Guidelines based on DME MAC article: "Correct Coding for Oral Appliances for the Treatment of Obstructive Sleep Apnea (E0486)" - Effective July, 01, 2012

Osteogenesis Stimulators

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

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

LCD and Policy Article Revisions Summary for April 9, 2015 (GEN)

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

Orthopedic Footwear

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

Removed: ICD-9 references

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Patient Lifts

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Vacuum Erection Devices

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: WOPD standard language

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

LCD and Policy Article Revisions Summary for April 16, 2015 (GEN)

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

Eye Prostheses

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Deleted: Reference to refill of supplies from Continued Use

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

POLICY SPECIFIC DOUMENTATION REQUIREMENTS:

Revised: Diagnosis code references for Cluster Headaches

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Pressure Reducing Support Surfaces - Group 1

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Revised: ACA 6407 verbiage

Added: Repair and Replacement section

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Walkers

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for equipment retained from a prior payer
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 11/01/2013 (April 2015 Publication)
CODING GUIDELINES:
Added: Coding guidelines to clarify billing for brakes upon initial issue.

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

LCD and Policy Article Revisions Summary for April 23, 2015 (GEN)

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

Pressure Reducing Support Surfaces - Group 2

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Removed: ICD-9 references
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Added: Repair and Replacement section

Pressure Reducing Support Surfaces - Group 3

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Added: Standard Documentation Language for detailed written order
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

Seat Lifts Mechanisms

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained From a Prior Payer

Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Removed: ICD-9 reference

Policy Article

Revision Effective Date: 11/01/2014 (April 2015 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Reference to ICD-9 Codes in the narrative

CODING GUIDELINES:

Revised: PDAC verbiage

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

LCD and Policy Article Revisions Summary for April 30, 2015 (GEN)

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

Ankle-Foot/Knee-Ankle-Foot Orthoses

LCD

Revision Effective Date: 05/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Added: Continued Need & Continue Use

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Updated: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article

Revised: Repair to beneficiary-owned DMEPOS

Revised: Instructions for HCPCS L2999

Policy Article

Revision Effective Date: 01/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Information for hospital and SNF reimbursement

CODING GUIDELINES:

Added: Reference to classification algorithm summary

Knee Orthoses

LCD

Revision Effective Date: 05/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Continued Need and Continued Use
Revised: Standard language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Updated: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article
Revised: Repair to beneficiary-owned DMEPOS
Revised: Instructions for HCPCS L2999

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information for hospital and SNF reimbursement

Spinal Orthoses: TLSO and LSO

LCD

Revision Effective Date: 05/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Deleted: Reference to refill of supplies from Continued Use
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: L0455 requires the CG modifier
Revised: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
CODING GUIDELINES:
Added: L0455 added to paragraph regarding items made of primarily nonelastic material

Suction Pumps

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Revised: Diagnosis code references
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Added: Repair/Replacement section
Revised: Diagnosis code references

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

LCD and Policy Article Revisions Summary for May 7, 2015 (GEN)

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Automatic External Defibrillators, Enteral Nutrition, External Breast Prostheses, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics), and Parenteral Nutrition. Please review each entire LCD and each related PA for complete information.

Automatic External Defibrillators

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Enteral Nutrition

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Instructions for Recertification DIF

Policy Article

Revision Effective Date: 10/31/2014

CODING GUIDELINES:

Updated: Standard language documentation for PDAC coding verification

External Breast Prostheses

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Moved: Continued Need above Continued Use documentation

Added: Instructions to the Refill Documentation section

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Equipment Retained from a Prior Payer

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

Revised: 3-drug combination coverage - Akynzeo® (netupitant with palonosetron) NK-1/5HT3 antagonist available - effective on and after 10/10/2014

DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Akynzeo® to the 3-drug combination billing and modifier instructions, effective on and after 10/10/2014

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: HCPCS Codes J8650, Q0161 - Q0180 to oral antiemetic drug coverage criteria
Revised: 3-drug combination regimen - Akynzeo® (netupitant with palonosetron) NK-1/5HT3 antagonist available - effective on and after 10/10/2014
CODING GUIDELINES:
Added: Akynzeo® (netupitant with palonosetron) NK-1/5HT3 antagonist available - effective on and after 10/10/2014

Parenteral Nutrition

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Instructions for Recertification DIF

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

LCD and Policy Article Revisions Summary for May 14, 2015 (GEN)

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Glucose Monitor, Pneumatic Compression Devices, Respiratory Assist Devices, Wheelchair Options/Accessories, and Wheelchair Seating. Please review each entire LCD and each related PA for complete information.

Glucose Monitor

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

Pneumatic Compression Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Respiratory Assist Devices

LCD

Revision Effective Date: 12/01/2014 (May 2015 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Added: Repair/Replacement section

Policy Article

Revision Effective Date: 12/01/2014 (May 2015 Publication)

NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:

Added: Non-coverage statement for liners used in conjunction with a PAP mask

Removed: "When required by state law" from ACA new prescription requirements

CODING GUIDELINES:

Added: Coding guidelines for liners used with PAP mask based on DME MAC article posted on February 13, 2014

Added: Coding guidelines for Monitoring Technology based on DME MAC article posted on November 15, 2013

Wheelchair Options/Accessories

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

Added: HCPCS Codes E2358 and E2359 to the Batteries/Chargers section

DOCUMENTATION REQUIREMENTS:

Deleted: Reference to refill of supplies from Continued Use

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

CODING GUIDELINES:

Revised: Removed HCPCS K0017 and K0018 from the initial package verbiage for armrest separate billing due to being parts of the whole assembly E0973 and only separately billed for replacement parts

Added: E0973 was added to the initial package verbiage for armrest separate billing due to being the whole assembly

Removed: The word "adjustable" was removed from the initial package verbiage for armrest separate billing due to fixed armrests K0020 being included

Wheelchair Seating

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Deleted: Reference to refill of supplies from Continued Use
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

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

LCD and Policy Article Revisions Summary for May 21, 2015 (GEN)

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Speech Generating Devices, Transcutaneous Electrical Joint Stimulation Devices (TEJSD), Transcutaneous Electrical Nerve Stimulators (TENS) and Vacuum Erection Devices (VED). Please review each entire LCD and each related PA for complete information.

Speech Generating Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

Transcutaneous Electrical Joint Stimulation Devices (TEJSD)

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements
CODING GUIDELINES:
Added: Statement regarding incorrect coding when billing unlisted claims for HCPCS E0762

Transcutaneous Electrical Nerve Stimulators (TENS)

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for Equipment Retained from a Prior Payer

Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

Vacuum Erection Devices (VED)

LCD

Revision Effective Date: 07/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Changed coverage indications for L7900 and L7902 to non-covered based on Achieving a Better Life Experience (ABLE) Act of 2014

Policy Article

Revision Effective Date: 07/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Changed coverage to non-covered based on ABLE Act of 2014

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

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 34.9%. A summary of findings was published on the NHIC, Corp. Web site on January 29, 2015. Based on this result, a widespread prepayment review was continued.

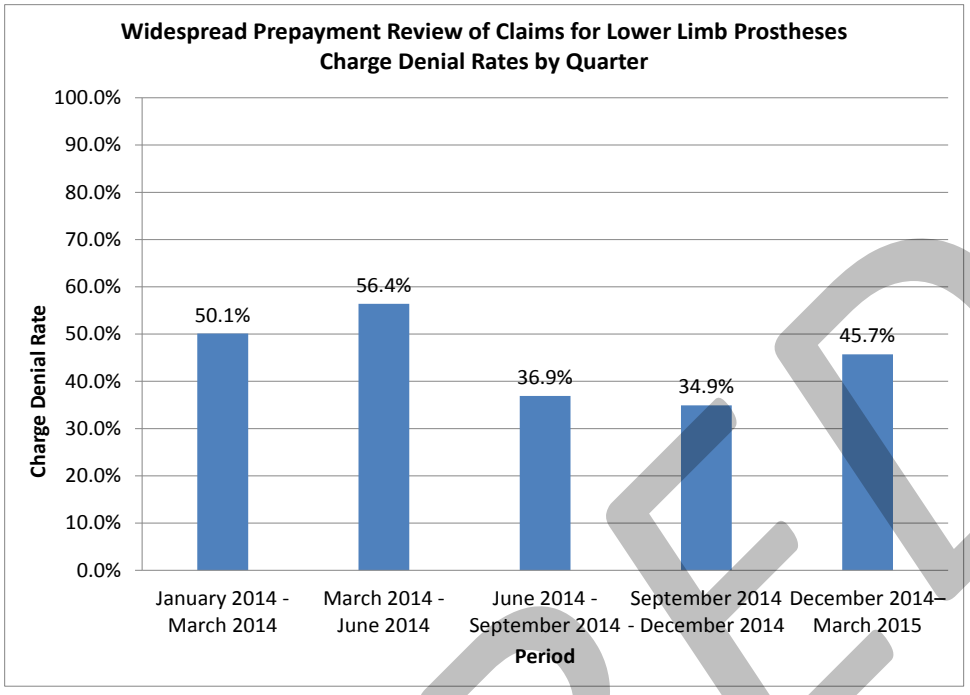
Current Review Results

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 and components/additions provided.

The review involved prepayment complex medical review of 179 claims submitted by 136 suppliers for claims processed December 16, 2014 to March 02, 2015. Responses to the Additional Documentation Request (ADR) were not received for 21 (12%) of the claims. For the remaining 158 claims, 67 claims were allowed and 91 were denied resulting in a claim denial rate of 58%. The overall Charge Denial Rate was 45.7%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Lack of Medical Record Documentation

- 23% of the denied claims had no medical record information submitted.

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

- 13% 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

- 12% 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

- 13% 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 also missing, verifying 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 suppliers' performance with providing complete and accurate supporting documentation and their response rate to Additional Documentation Requests (ADRs). When a supplier achieves and maintains high quality accuracy and ADR response rate over three (3) quarterly periods, the supplier will be temporarily removed from that particular widespread review. The supplier's authorized official will be notified and provided details of this decision.

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

Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- 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 04/24/2014, 07/24/2014, 10/23/2014, 01/29/2015)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Results of Widespread Prepayment Probe for Lower Limb Prostheses (Posted 11/30/2011)
  http://www.medicarenhic.com/viewdoc.aspx?id=353

Results of Widespread Prepayment Probe Review of Claims for E0464 (Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask)) (SPE)

The DME MAC Jurisdiction A has completed the prepayment probe review of claims for HCPCS code E0464. This review was initiated due to an increase in billing identified by data analysis.

The review involved prepayment complex medical review of 135 claims submitted by 53 suppliers. These claims were reviewed from December 8, 2014 - February 17, 2015. Responses to the Additional Documentation Request (ADR) were not received for 12 (9%) of the claims. For the remaining 123 claims, 11 claims were allowed and 112 were denied resulting in a claim denial rate of 91%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 90.2%.

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%:

Clinical Documentation Issues

- Medical documentation included did not demonstrate (96%);
  - Neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.
  - Documentation of disease severity that was comprised of conditions for whom interruption or failure of respiratory support leads to death.

Detailed Written Order Issues

- Missing complete written order prior to delivery (WOPD) that has been signed and dated by treating physician (27%)

Proof of Delivery Issues

- No Valid Proof of Delivery (0.9%)

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.

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating clinician's signature, date of clinician's signature and start date of order; Clinical documentation supporting the item is reasonable and necessary and includes name of beneficiary, date of appointment, and clinician's signature.
Missing: Proof of delivery, with all of the required elements

Example 2:

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

Missing: Valid proof of delivery for date of service

Example 3:

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

Missing: Clinical documentation to support the item is reasonable and necessary.

Next Step

Based upon the results of initial prepayment review, DME MAC A will continue to review claims for HCPCS code E0464 (Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask))

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

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

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for HCPCS code E0464. 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:

- Correct Coding and Coverage of Ventilators - Joint DME MAC Publication
  http://www.medicarenhic.com/viewdoc.aspx?id=2653

- *National Coverage Determinations* (NCD) (Internet-Only Manual, Pub. 100-03) in Chapter 1, Part 4, Section 280.1
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part4.pdf

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

Historical Review Results

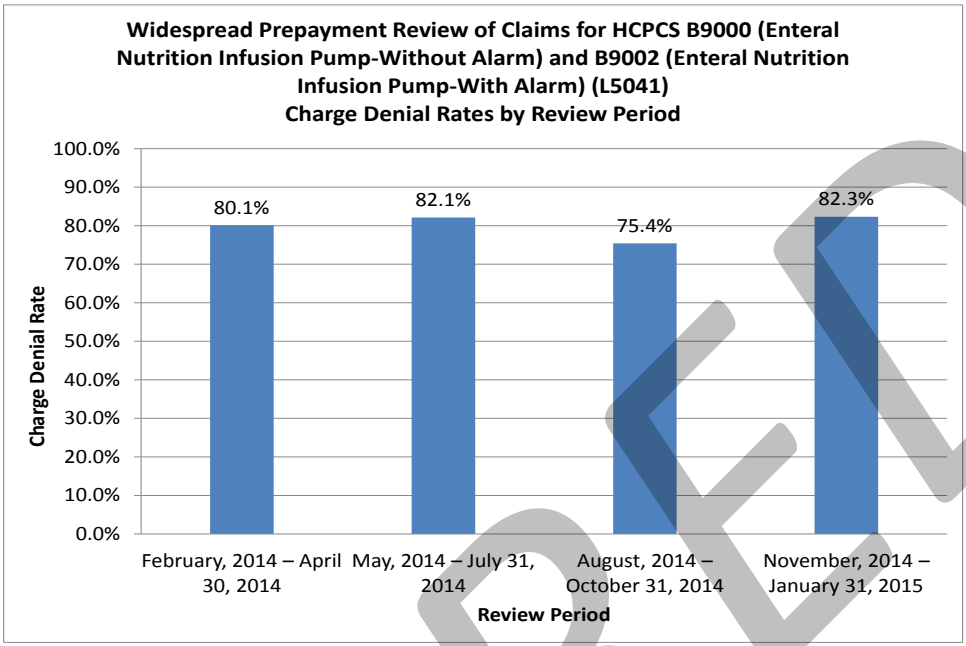
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The result of the total denied allowance amount (dollar amount of allowable charges 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 August 1, 2014 through October 31, 2014 and resulted in CDR of 75.4%.

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 and B9002. These findings include claims processed primarily from November 1, 2014 through January 31, 2015.

The review involved prepayment complex medical review of 849 claims submitted by 121 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 138 (16%) of the claims. For the remaining 711 claims, 71 claims were allowed and 640 were denied/partially denied resulting in a claim denial rate of 90% and a CDR of 82.3%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Clinical Documentation Issues

- 10% of the denied claims did not include clinical documentation.
- 31% claims had insufficient clinical documentation to justify the LCD criteria.
  Note: *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 30% of the claims did not meet the prosthetic benefit requirement.

Proof of Delivery

- 15% of the denied claims had no proof of delivery.
- 18% of the claims had incomplete delivery information.
  - No proof of receipt by the beneficiary.
  - Unable to match and verify through name, use of order numbers, and/or conflicting tracking numbers.

Detailed Written Order Issues

- 15% of the denied claims did not include a detailed written order.
- 10% of the denied claims had incomplete detailed written orders.
  - Date of the detailed order was incomplete (missing month or year) on the supplier generated detailed physician order
  - Physician signature could not be authenticated

DME Information Form (DIF)

- 5% of the denied claims were missing a DIF
- 1% of the denied claims were missing 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: Proof of delivery, detailed written order, clinical documentation, DIF
Missing: Revised DIF (number of calories per day and HCPCS code for the nutrient have changed)

Example 2:

Received: Clinical documentation, proof of delivery, DIF
Missing: Date of physician's signature on detailed written order

Example 3:

Received: DIF, proof of delivery, detailed written order.
Missing: Clinical documentation that would support reasonable & necessary

Next Step

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

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

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

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

Educational References

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

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

- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (Posted 12/18/2014; 09/25/2014; 06/26/2014; 03/27/2014; 12/27/2013; 09/13/2013; 06/28/2013; 03/8/2013; 7/20/2012; 05/11/2012; 12/22/2012; 09/20/2011; 03/11/2011)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

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

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

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

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

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

Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (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 August 2014 through October 2014, and reported a CDR of 83.7%.

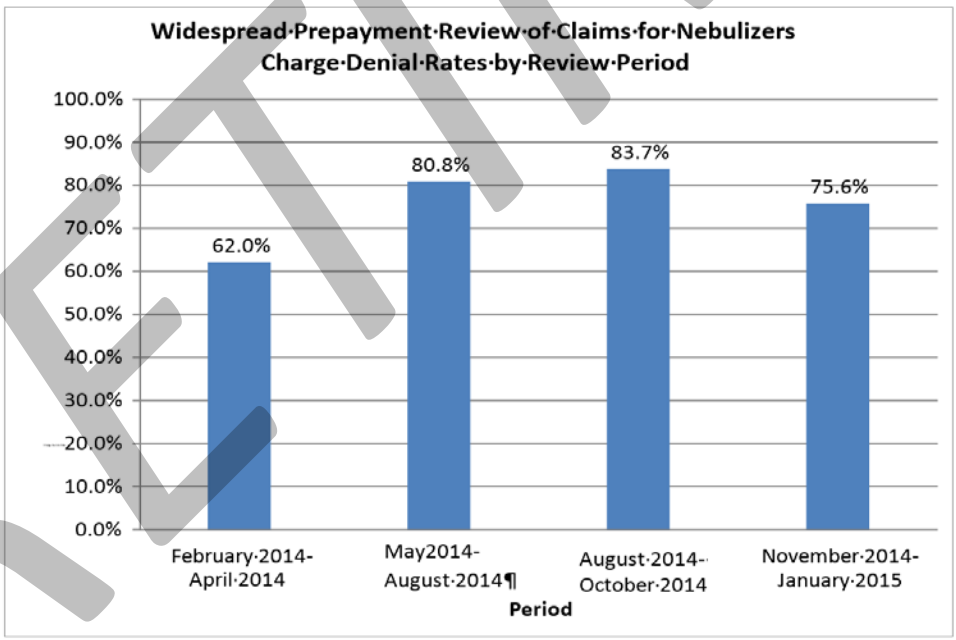
Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from November 2014 through January 2015.

The review involved prepayment complex medical review of 2,064 claims submitted by 765 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 441 (21%) of the claims. For the remaining 1,623 claims, 197 claims were allowed (12%) and 1426 were denied/partially denied resulting in a claim denial rate of 88%. The overall CDR was 75.6%.

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

- 24% of the denied claims were missing clinical information to support reasonable and necessary.
  - No medical records were submitted
- 24% of the denied claims had insufficient or incomplete clinical documentation. The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer
    - Clinical documentation submitted did not mention a payable medical condition
    - Clinical documentation submitted 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 were missing the written order prior to delivery.
- **75% of the denied claims had an incomplete or invalid written order prior to delivery.**
  The following are specific 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.
- 12% of the denied claims had an incomplete or invalid proof of delivery. The following are specific issues identified:
  - Illegible copy of proof of delivery
  - Missing sufficiently detailed description to identify the item(s) being delivered
  - Missing beneficiary (or designee) signature when item(s) are delivered directly by the supplier to the beneficiary
  - Nebulizer (first month rental) delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier(Method I)
  - Nebulizer (first month rental) shipped either before or after the date of service of the claim when the item(s) is shipped via a shipping service or delivery service (Method II) directly to a beneficiary

Claim Examples

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

Example 1:

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's signature, date of signature, physician's NPI number, clinical notes and proof of delivery
Missing: 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 supplies item(s). Proof of delivery missing a sufficiently detailed description (e.g., brand names, serial number, narrative description) of an E0570 nebulizer compressor.

Example 2:

Received: Written Order Prior to Delivery (WOPD) with: beneficiary name, description of item to be dispensed, physician's 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.
Missing: Clinical notes do not explain reasonable and necessary use of a nebulizer. Missing a proof of delivery.

Example 3:

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

Missing: The WOPD is missing the physician's NPI number. 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).

Next Step

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

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

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

Educational References

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

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective July 2013 (A24944)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review of Claims for E0570
  (Posted 03/20/2014; 06/26/2014; 09/25/2014; 12/18/2014)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- 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 - Live Line Chat (Monday 9:00am - 11:00am and Thursday 1:00pm - 3:00pm) -The Monday chat sessions will provide the opportunity to ask billing, policy, documentation and other general questions to the Outreach & Education Team **http://www.medicarenhic.com/dme/rcseminars.aspx#liveline**

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 October 01, 2014 through December 31, 2014 and resulted in a CDR of 70.4%.

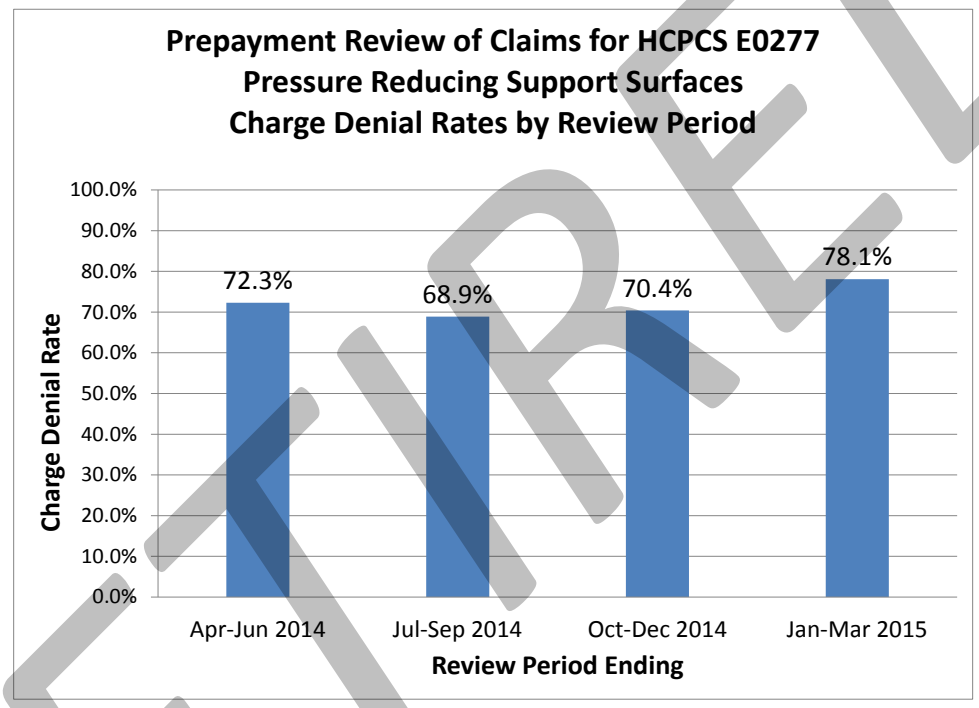
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Group 2 Pressure Reducing Support Surfaces (HCPCS Code E0277). These findings include claims with dates processed from January 01, 2015 through March 31, 2015.

The review involved prepayment complex medical review of 240 claims submitted by 69 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 50 (21%) of the claims. For the remaining 190 claims, 49 were allowed and 141 of the claims were denied. This resulted in a claim denial rate of 74%, and a CDR of 78.1%.

Historical CDR Data

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



Primary Reasons for Denial

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

Medical Documentation

- 47% 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.
- 13% of the denied claims did not include medical documentation.
- 2% of the denied claims included medical records that were not signed by the treating clinician.

Written Order Prior to Delivery

- 21% of the denied claims included a written order prior to delivery that was missing an order date/start date.

- 11% 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.
- 4% of the denied claims included detailed written order that was dated after delivery.
- 3% of the denied claims were missing a written order prior to delivery.

Proof of Delivery Issues

- 9% of the denied claims included proof of delivery that had a delivery date that was different than the date of service.
- 4% of the denied claims were missing a proof of delivery.
- 2% of the denied claims included proof of delivery that were missing the beneficiary's (or designee) signature

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, and physician signature and signature date;
- Medical records consisting of a doctor's visit and visiting nurse notes.
- Proof of delivery which includes the beneficiary's name, delivery address, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Missing:

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

Example 2

Received:

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

Missing:

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

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

Next Step

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

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

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

Educational References

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

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

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

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

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

- Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Results of Widespread Prepayment Complex Medical Review for Group 2 Pressure Reducing Support Surfaces (published 02/25/2014; 05/29/2014; 09/25/2014; 11/26/2014; 02/26/2015)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Supplier Self Audits
  http://www.medicarenhic.com/dme/selfaudits.aspx

Results of Widespread Prepayment Review of Claims for HCPCS E0601, (Continuous Positive Airway Pressure Devices) (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 October 2014 through December 2014, and reported a CDR of 74.10%.

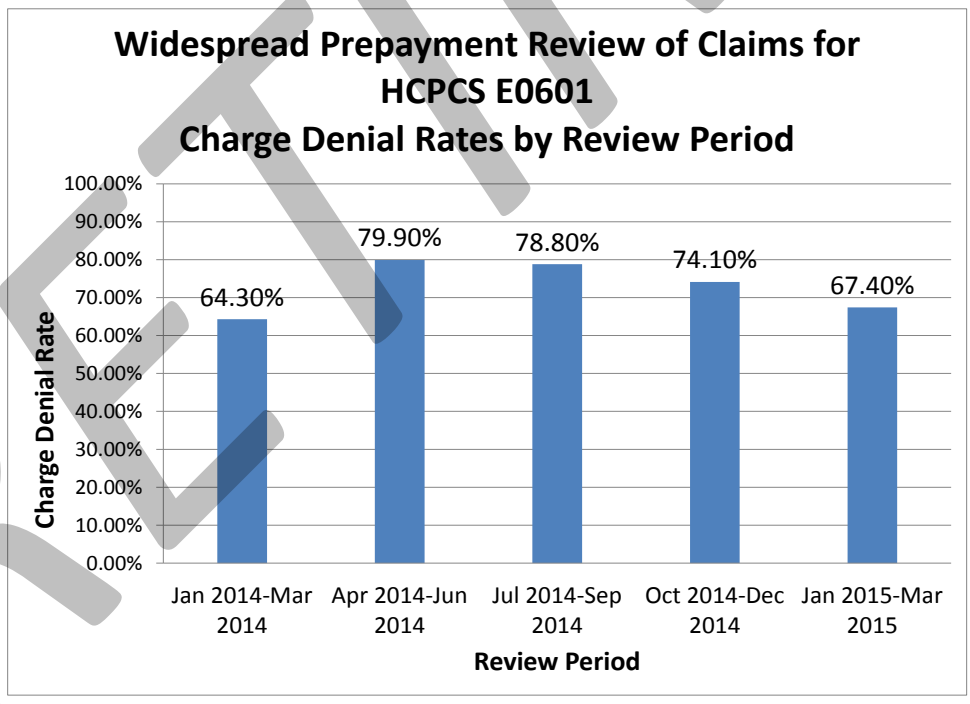
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from January 2015 through March 2015.

This review involved prepayment complex medical review of 2,315 claims submitted by 402 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 413 (18%) of the claims. Of the 1,902 claims for which responses were received, 505 claims were allowed and 1,397 were denied/partially denied. This resulted in a claim denial rate of 74%. The overall CDR was 67.4%.

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

- 13.4% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination (LCD).
- These claims had no Face-to-Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement. Scenarios included are as follows:
    A. Beneficiaries seeking initial coverage of a PAP device
    B. Beneficiaries seeking PAP replacement following the 5 year RUL
    C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare
- 10% of the denied claims had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP LCD. The insufficient clinical documentation included:
    - Clinical documentation provided did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
    - Face-to-Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued to benefit from sleep therapy.
    - Insufficient clinical documentation noted in Face-to-Face evaluations conducted by the treating physician in claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering Fee-for-Service (FFS) Medicare.
- 4% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 2.7% of the denied claims had Face-to-Face clinical evaluations which were untimely. Timely documentation is defined as a record in the preceding 12 months as per the PAP LCD.

Detailed Written Order/Written Order Prior to Delivery Issues

- 2.6% of the denied claims did not include the Detailed Written Order.
- 62% 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 on Detailed Written Order Prior to Delivery
    G. A date of receipt demonstrating supplier received the Detailed Written Order on or before the Delivery
- 63.9 % 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
    F. Replacement items are billed on initial E0601 claim which is not permitted.
    G. Detailed description specific to mask

  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

Sleep Study Documentation Issues

- 5% of the denied claims did not include a copy of the original Sleep Test that meets the Medicare coverage criteria.
- 3% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 5.2% of the denied claims had no practitioner's signature on the Sleep Test that meets the Medicare coverage criteria.
- 2% of the denied claims were missing Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 10% of the denied claims did not include evidence of training on the PAP device.

- 10.6% 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

- 4.5% of the denied claims were missing Proof of Delivery.
- 6.2% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature.

Claim Examples

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

Example 1:

Received: Included in this claim are a Detailed Written Order/Written Order Prior to Delivery, a Sleep Test that meets the Medicare coverage criteria, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The submitted documentation did not include a Face-to-Face clinical evaluation by the treating physician.

Example 2:

Received: Included in this claim for Initial coverage of a PAP device are a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, and Proof of Delivery, evidence of Training on the PAP device and a diagnostic Sleep Test.
Missing: The Face-to-Face clinical evaluation submitted is dated after the diagnostic Sleep Test.

Example 3:

Received: Included in this claim are 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 the beneficiary received instruction for the application and use of a portable sleep monitoring device either by face-to-face, video or telephonic instruction.

Next Step

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

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

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

Educational References

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

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

- Results of Widespread Prepayment Review of Claims for HCPCS E0601 (Continuous Positive Airway Pressure Devices) (Posted 02/26/2015, 11/21/2014; 09/18/2014; 05/29/2014; 02/27/2014; 11/22/2013; 08/30/2013; 05/31/2013; 02/28/2013;

11/30/2012; 08/24/2012; 04/20/2012; 12/22/2011; 08/19/2011; 03/04/2011; 07/02/2010)
http://www.medicarenhic.com/dme/mrbulletinpca.aspx

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

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

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

- Physician's Corner Checklists
  http://www.medicarenhic.com/dme/mobile/index.html

Results of Widespread Prepayment Review of Claims for L0631/L0637, Lumbar-Sacral Orthoses (L11470) (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 August 29, 2014 through December 12, 2014 and the reported CDR was 82.3%.

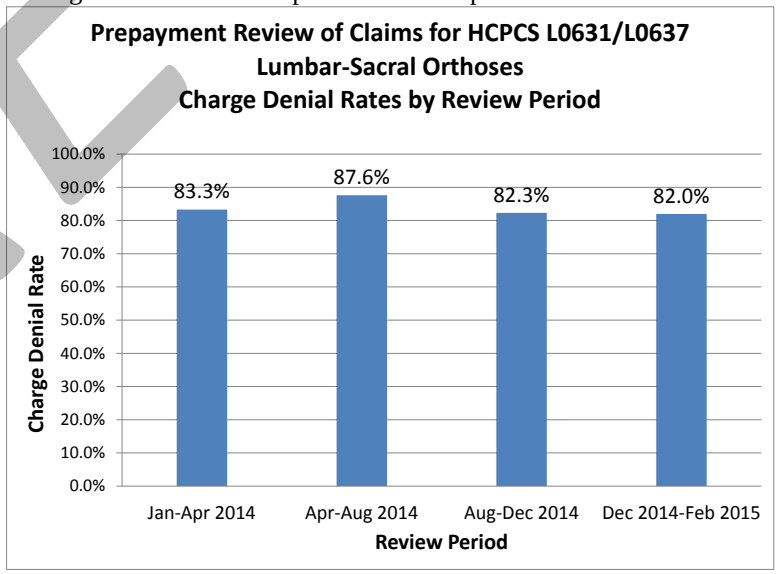
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Lumbar-Sacral Orthoses (HCPCS L0631 and L0637). These findings include claims processed primarily from December 2014 through February 2015.

The review involved prepayment complex medical review of 1841 claims submitted by 322 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 942 (51%) of the claims. For the remaining 899 claims, 157 claims were allowed and 742 denied resulting in a claim denial rate of 83%. The overall CDR was 82.0%.

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) (13%)
- Denied claims included an incomplete order (23%)
- DWOs submitted were not legible and/or did not list beneficiary name (3%)
- DWOs missing start date and/or signature date (9%)
- DWOs do not specifically detail the item(s) (11%)

Medical Record Documentation Issues

- Denied claims missing the clinical documentation to support medical necessity (10%)
- Denied claims upon review of clinical documentation (24%)
    - Clinician notes submitted show a different beneficiary than stated within the claim submitted (3%)
    - 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 (15%)
    - Medical documentation was not authenticated by the clinician conducting the exam (6%)

Proof of Delivery Issues

- Denied claims were missing the Proof of Delivery (POD) (14%)
- Proof of Delivery (POD) included delivery documentation which was missing required elements (14%)
    - Delivery documentation (Method 1) did not include signature of beneficiary or beneficiary's representative; unable to determine beneficiary received items billed (2%)
    - Dates of service do not match shipping/receipt dates for items, as defined within the LCD (L11470) (2%)
    - Delivery documentation does not specifically describe item(s) delivered (4%)
    - Delivery documentation does not include delivery address. (5%)

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 DWO, which includes the beneficiary's name, treating clinician's signature, date of clinician's signature and start date of order.

Missing: DWO submitted did not include specific description of item(s) being ordered. Clinical documentation to support medical necessity of item which includes the name of beneficiary and clinician's signature. Delivery documentation submitted did not include specific date supply item(s) were received by beneficiary.

Example 2:

Received: The supplier submitted clinical documentation to support medical necessity. Proof of delivery, with all of the required elements was submitted.

Missing: A DWO, which includes the beneficiary's name, specific item(s) to be dispensed, treating clinician's signature and start date of order.

Example 3:

Received: The supplier submitted a DWO, which includes the beneficiary's name, treating clinician's signature, date of clinician's signature and start date of order. The supplier submitted clinical documentation to support medical necessity.

Missing: A valid proof of delivery, with all of the required elements, was not submitted.

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.

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.

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

Educational References

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

- LCD for Spinal Orthoses: TLSO and LSO (L11470)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- 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

Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment, HCPCS E1390, E0431, and E0439 (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 October 01, 2014 through December 31, 2014 and resulted in a CDR of 60.6 %.

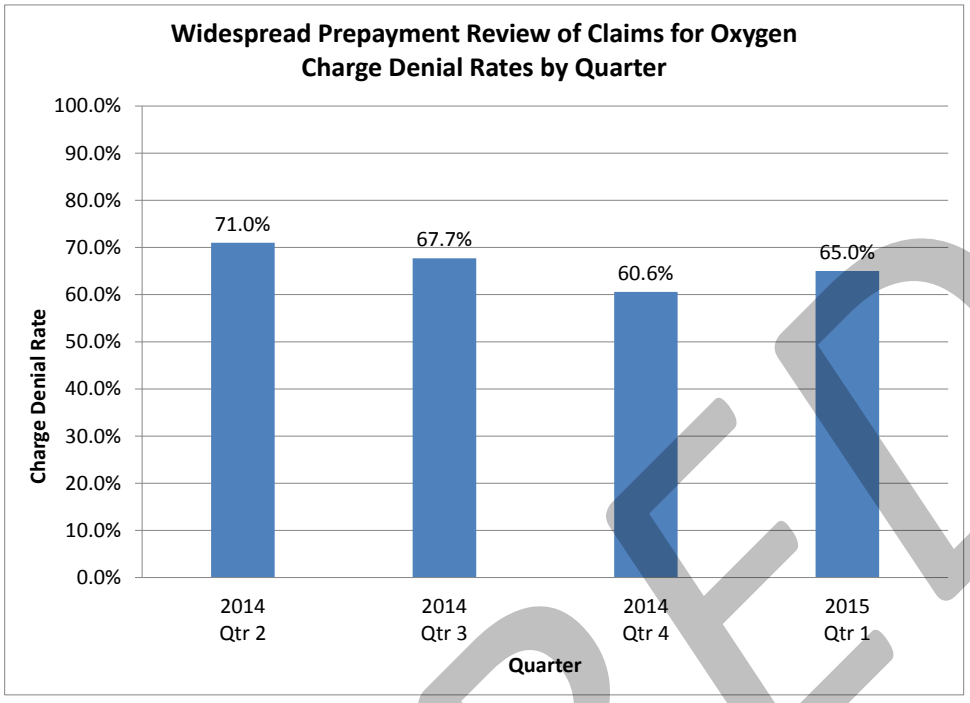
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from January 01, 2015 through March 31, 2015.

The review involved prepayment complex medical review of 1,195 claims submitted by 165 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 602 (50%) of the claims. For the remaining 593 claims, 175 claims were allowed and 418 were denied resulting in a claim denial rate of 70%, and a CDR of 65%.

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) L11468 and related Policy article for additional information.

Primary Reasons for Denial

The following are the primary reasons for denial.

Written Order Prior to Delivery Requirements Not Met (48%)

Documentation did not meet the written order prior to delivery requirements for items E0431 and E0439 outlined in LCD L11468 for dates of service on or after January 01, 2014 for the following reasons:

- No evidence, by date stamp or similar, that the supplier received the detailed written order prior to delivery (49%)
- Detailed written order was missing a detailed description of the DME item(s) ordered (40%)
- Detailed written order was missing the prescribing practitioner's NPI (19%)
- Detailed written order was signed after the date of delivery (20%)
- Detailed written order was received after the date of delivery (12%)
- Detailed written order was missing the order date (5%)

- No detailed written order was submitted (4%)
- Date of receipt by the supplier is a poor copy and is illegible (3%)
- Detailed written order was signed after the date of receipt (3%)
- Correction was made to the detailed written order without the author's initials and the date of the correction (3%)
- Detailed written order was illegible (2%)
- Detailed written order was missing the signature date (1%)
- Detailed written order was missing the prescribing practitioner's name (1%)

Missing Documentation (36%)

Missing required physician visit per Local Coverage Determination (LCD) L11468:

- 17% - Missing treating physician visit within 30 days prior to the initial certification date

Missing qualifying blood gas study per LCD L11468:

- 5% - No medical documentation to support the blood gas study reported on the CMN

Missing required Certificate of Medical Necessity (CMN) per LCD L11468:

- 6% - No initial CMN submitted or initial CMN was invalid
- <1% - No recertification CMN submitted

Missing required Detailed Written Order per LCD L11468:

- 2% - No detailed written order submitted or detailed written order was invalid

Missing valid proof of delivery per LCD L11468:

- 5% - 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
  - Proof of delivery missing the delivery address
  - Proof of delivery missing the delivery date

Clinical Documentation Issues: Medical Necessity could not be established (16%)

Clinical documentation did not support criteria of LCD L11468 for the following reasons:

- 5% - 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
- 4% - 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
  - Documentation did not support that the beneficiary had a saturation at or above 89 percent during the day while at rest
- 3% - No indication in the medical documentation of the presence of a severe lung disease or hypoxia-related symptoms
- 1% - Medical documentation did not demonstrate that the beneficiary was tested while in a chronic stable state
- 1% - Replacement oxygen requirements not met
  - Missing the RA modifier and a narrative explanation of why the equipment was replaced
- 1% - Missing documentation of a titration polysomnogram for a beneficiary with obstructive sleep apnea
- <1% - No documentation of testing on 4 LPM
- <1% - No documentation submitted
- <1% - Medical records missing the beneficiary's name
- <1% - Group I or II criteria not met
  - Oxygen saturation on the CMN was greater than 89 percent

Claim Examples

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

Example 1:
DOS 10/21/2014
Code(s) Billed: E1390, E0431

Documentation received: Initial CMN dated 10/21/14; detailed written order signed and dated 10/21/14; progress note supporting the blood gas study results reported on the CMN; physician progress notes dated 10/20/14; proof of delivery dated 10/21/14; supplier forms
Missing: Proof of receipt prior to delivery on the detailed written order; documentation in the medical record of the presence of a severe lung disease or hypoxia-related symptoms; author's signature on the progress note supporting the blood gas study results on the CMN

Example 2:
DOS 10/28/2014
Code(s) Billed: E0431

Documentation received: Written order prior to delivery dated 10/27/14 and received 10/28/14; initial CMN dated 10/28/14; physician attestation letter; flow-sheet from the treating provider documenting the results of the blood gas study reported on the CMN; proof of delivery form dated 10/28/14; supplier forms
Missing: A detailed description of the DME item ordered on the written order prior to delivery; documentation of a physician visit dated within 30 days prior to the initial certification date; a description of the item billed on the proof of delivery

Example 3:
DOS 10/1/2014 - 12/1/2014
Code(s) Billed: E1390

Documentation received: Prescription order dated 09/29/14; initial CMN dated 10/01/14; physician progress notes dated 10/01/14 and 09/19/14; proof of delivery dated 10/01/14; supplier forms
Missing: Legible results of the qualifying blood gas study documented on the CMN; treating physician's signature on the progress notes

Next Steps

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS E1390, E0431 and E0439.

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

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

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- 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

- 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 and Oxygen Equipment Documentation Checklist
  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: 02/262015; 11/21/2014; 09/18/2014; 05/29/2014; 02/25/2014; 11/27/2013; 08/30/2013; 05/17/2013; 02/08/2013; 10/12/2012; 06/29/2012; 03/02/2012; 11/04/2011; 08/26/2011; 11/05/2010; 06/09/2010)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

Widespread Prepayment Probe for HCPCS Code L1940 (Ankle-Foot Orthosis) (O&P)

DME MAC A will be initiating a widespread prepayment probe of claims for the following HCPCS code:

L1940 (ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, CUSTOM-FABRICATED)

This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

The Local Coverage Determination (LCD) for Ankle-Foot/Knee-Ankle-Foot Orthosis (L11527) states:

HCPCS Code L1940 is covered for ambulatory 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.

AFOs and KAFOs that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria listed above and one of the following criteria is met:
1. The beneficiary could not be fit with a prefabricated AFO; or,
2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or,
3. There is a need to control the knee, ankle or foot in more than one plane; or,
4. The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
5. The beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

For custom fabricated orthoses, there must be detailed documentation in the treating physician's records to support the medical necessity of custom fabricated rather than a prefabricated orthosis as described in the Coverage Indications, Limitations and/or

Medical Necessity section of LCD L11527. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records.

If a custom fabricated orthosis is provided but basic coverage criteria above and the additional criteria 1-5 for a custom fabricated orthosis are not met, the custom fabricated orthosis will be denied as not reasonable and necessary.

Suppliers will be sent a documentation request letter for the information listed below. The requested documentation must be returned within 45 days from the date of the letter to avoid claim denials.

1. Documentation should include the following items:
    - Physician order for the item. Include both the dispensing order (if applicable) and the detailed written order which includes the following elements:
    - Beneficiary's name
    - Physician's name
    - Date of the order and the start date, if start date is different from the date of the order
    - Detailed description of the item(s)
    - Physician signature and signature date

2. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item is met

3. Proof of delivery which includes elements specified in LCD L11527 for the following delivery methods:
    - Delivery directly to the beneficiary or authorized representative (Method 1)
    - Delivery via shipping or delivery service (Method 2)
    - Delivery of items to a nursing facility on behalf of the beneficiary (Method 3)

4. Any other pertinent information that would justify payment for the item(s) provided.

5. Advanced Beneficiary Notice (ABN), if one was obtained, must be submitted with the above requested documentation.

To avoid unnecessary denials for missing or incomplete information, please ensure when submitting documentation requests that all requested information is included with your file and respond in a timely manner.

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy Article. Suppliers can review the LCD for Ankle-Foot/Knee-Ankle-Foot Orthosis (L11527) and the related Policy Article (A19806) on the NHIC Web site at: **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

Widespread Prepayment Probe for HCPCS Code L4360 (Pneumatic Walking Boot) (O&P)

DME MAC A will be initiating a widespread prepayment probe of claims for the following HCPCS code:

L4360 (WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE)

This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

The Local Coverage Determination (LCD) for Ankle-Foot/Knee-Ankle-Foot Orthosis (L11527) states:

HCPCS Code L4360 is covered for ambulatory 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.

Items requiring substantial modification by a qualified practitioner (as defined in the related Policy Article Coding Guidelines) are coded as custom fitted. Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary.

Custom fitted orthotics are:

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

If the basic coverage criteria for an AFO or KAFO is not met, the orthosis will be denied as not reasonable and necessary.

Claims for custom fitted orthoses will be denied as incorrect coding, with a statutory denial, when documentation shows that only minimal self-adjustment was required at the time of fitting (see Policy Specific Documentation Requirements section in the Local Coverage Determination).

Suppliers will be sent a documentation request letter for the information listed below. The requested documentation must be returned within 45 days from the date of the letter to avoid claim denials.

Documentation should include the following items:

1. Physician order for the item. Include both the dispensing order (if applicable) and the detailed written order which includes the following elements:
    - Beneficiary's name
    - Physician's name
    - Date of the order and the start date, if start date is different from the date of the order
    - Detailed description of the item(s)
    - Physician signature and signature date

2. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item is met as well as documentation from a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.

3. Proof of delivery which includes elements specified in LCD L11527 for the following delivery methods:
    - Delivery directly to the beneficiary or authorized representative (Method 1)
    - Delivery via shipping or delivery service (Method 2)
    - Delivery of items to a nursing facility on behalf of the beneficiary (Method 3)

4. Any other pertinent information that would justify payment for the item(s) provided.

5. Advanced Beneficiary Notice of Noncoverage (ABN), if one was obtained, must be submitted with the above requested documentation.

To avoid unnecessary denials for missing or incomplete information, please ensure when submitting documentation requests that all requested information is included with your file and respond in a timely manner.

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy Article. Suppliers can review the LCD for Ankle-Foot/Knee-Ankle-Foot Orthosis (L11527) and the related Policy Article (A19806) on the NHIC Web site at: **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

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 is currently available for open enrollment. **There is no charge to participate!**

Billing Reminder: Supplies Provided On a Periodic Basis (SPE)

For supplies that are provided on a recurring basis, including ostomy and urological supplies, the general rule is that suppliers may dispense no more than a three (3) month supply at any one time. However, for refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, and oral antiemetic drugs, only a one (1) month quantity of supplies may be dispensed at a time.

For items which are dispensed for greater than a one (1) month supply at a time; suppliers are reminded to include information in the narrative field to indicate "2 month supply" or "3 month supply." Additionally, if a beneficiary is changing from a one (1) month supply to a three (3) month supply or a similar scenario; suppliers should include a notation indicating this change such as "Change from 1 month to 3 month supply." Inclusion of this additional information in the claim narrative will ensure appropriate payments and avoid unnecessary appeals.

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

Notification of Certificate of Medical Necessity (CMN) and DME Information Form (DIF) Revisions (GEN)

The Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs) have been revised in preparation for the October 01, 2015 implementation of International Classification of Diseases version 10 (ICD-10). These changes have been reviewed and approved by the Office of Management and Budget (OMB). Below are the principal changes to the CMN and DIF forms in preparation for the implementation of ICD-10:

- *ICD-9 diagnosis* was removed and replaced with *diagnosis code*; and
- *Healthcare Common Procedure Coding System (HCPCS) code* was removed and replaced with *supply item/procedure code*.

The CMNs and DIFs listed below have been revised and posted to the Center for Medicare & Medicaid Services (CMS) and NHIC web sites. The revised version of the CMN forms must be used on all claims for services provided on or after October 01, 2015.

The following revised CMNs and DIFs are available at: **http://www.medicarenhic.com/dme/forms.aspx**

CMS-484	Oxygen
CMS-846	Pneumatic Compression Devices
CMS-847	Osteogenesis Stimulators
CMS-848	Transcutaneous Electrical Nerve Stimulator (TENS)
CMS-849	Seat Lift Mechanisms
CMS-10125	External Infusion Pumps
CMS-10126	Enteral and Parenteral Nutrition

Fax Submission Tips and Reminders (GEN)

Thank you for your patience in May while DME MAC Jurisdiction A worked through our intermittent fax transmission issue. We would like to take this opportunity to share a few fax tips that will help us ensure a smooth process.

Faxes are accepted for Reopening, Redetermination, Overpayment, and General Inquiry Requests as well as responses to Automated Development Requests (ADR).

- Following the fax guidelines listed below will ensure the prompt receipt and accurate department assignment of your fax:
- Please include a cover sheet with your fax indicating your company name, a contact person, a telephone number and a fax number.

- Please indicate how many pages you are faxing.
- Be sure your fax machine is set for the correct date. This date should be the date you are faxing to NHIC.
- Send each fax as a separate submission. Combining multiple fax requests into a single fax may cause a delay in routing the faxes to the appropriate area for processing.
- A fax should contain all requested documentation. Do not send multiple faxes as a response to one request for documentation.
- Check that all pages are right side up, with the top of each page at the top of your fax machine, before faxing.
- Complete the correct form when sending your request. Please visit the "Forms" page of our web site at: **http://www.medicarenhic.com/dme/forms.aspx**
- Using the correct fax number will assist in routing faxes to the correct department.
- The following fax numbers should be used:

781-741-3118	or	781-741-3840	- Redetermination Requests
781-741-3914	or	781-741-3842	- Reopening Requests
		781-383-4513	- Overpayment Requests
		781-741-3916	- Immediate offset requests
		781-741-3833	- Medical Review ADR responses
		781-741-3991	- Medical Review ADMC Requests
		781-741-3545	- Documented Compliance Review (DCR) ADR responses
		781-383-4519	- PMD Prior Authorization Requests
		781-741-3118	- Written inquiries

- If responding to a request for documentation, please send a copy of the request with the documentation. It is helpful for the request to be at the beginning of your fax to speed departmental routing.
- If you have requests or documentation for different NPI numbers, please fax separately as each fax must receive a unique control number for processing purposes.
- Please be sure your office receives a confirmation that all pages of the fax were received. Only complete faxes will be submitted for processing.
- Consider mailing requests with multiple pages. Depending on the size of the document and the condition of the documentation, mailing the documentation may be the better option than faxing. Contact information, including mailing addresses can be found at **http://www.medicarenhic.com/dme/contactshome.aspx**

First 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 January through March 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	87,987	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	21,555	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	14,031	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.	10,188	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.351.2400.SV101-7.020 This Claim is rejected for relational field Information within the Detailed description of service	9,696	Description must be present when Procedure Code requires a description/additional information.
X222.087.2010AA.NM109.030 Invalid information in the Billing Provider's NPI	7,974	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.351.2400.SV101-3.020 This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	7,919	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.380.2400.DTP03.090 Invalid Information within the Date(s) of service	7,623	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
X222.380.2400.DTP03.080 Invalid Information within the Future date and Date(s) of service	6,686	The service start/from date is greater than the date this claim was received.
X222.226.2300.HI01-2.030 Invalid Information within the Primary diagnosis code	6,681	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.

First 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 first 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 January through March 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.	28,170
OA109, N418 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	11,493
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.	8,432
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.	2,947
CO 16, MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	1,897
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.	1,440
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.	1,082
CO 16 N51 Electronic interchange agreement not on file for provider/submitter.	**Item 33** The PTAN/NSC on file is not eligible to submit electronic claims.	893
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.	855
CO 111 Not covered unless the provider accepts assignment	**Item 27** The procedure code billed must be submitted as assigned.	715

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above charts and share it with your colleagues.

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly Bulletins and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at:
http://www.medicarenhic.com/dme/listserve.html

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at
http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html.
CMS encourages you to bookmark this Web site and visit it often for this valuable information.

Supplier Manual News (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) *Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/publications.aspx**. After accepting the CPT License Agreement, suppliers can access the entire DME MAC A *Supplier Manual*, including revised chapters and archived revisions.

Updates/Corrections Made:

In March of 2015 chapters 1, 2, 3, 10, 12, and Appendix A of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

Updating Supplier Records (GEN)

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information must be reported in writing to the NSC within 30 days after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier must then verify their address with the NSC in writing.

Note: *A request to change your address should not be sent to DME MAC A since we cannot change supplier files.*

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms web site at:
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

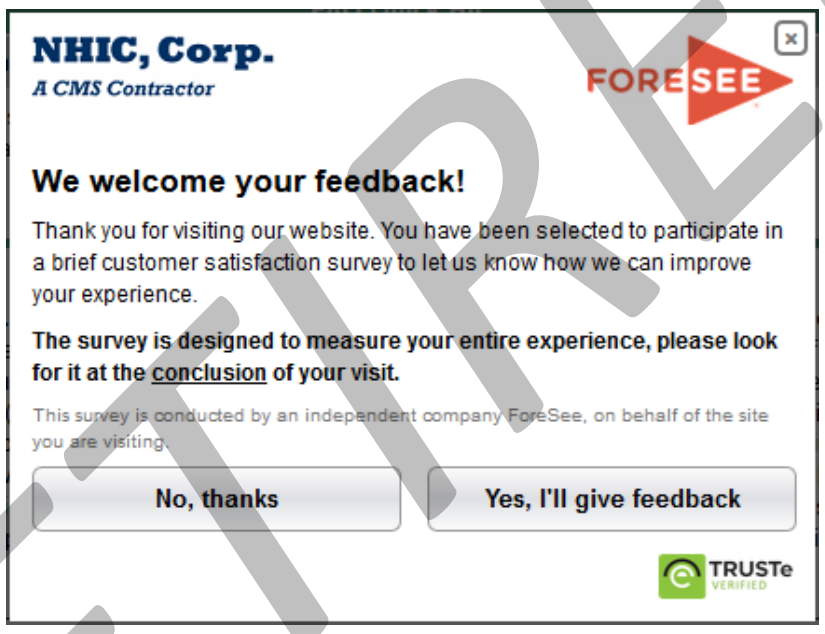
DME MAC Jurisdiction A Web Site Customer Satisfaction Survey

NHIC, Corp. DME MAC Jurisdiction A is committed to ensuring that our Web site meets the needs of our users. We continually strive to improve our offerings based on the information and feedback we receive from you. In order to accomplish this, we offer *The DME MAC A Web site Customer Satisfaction Survey*. This survey is designed to collect information that helps measure providers' satisfaction with contractors' Web sites with a focus on customer service.

If you see the **Customer Satisfaction Survey** pop up while you are browsing the DME MAC A Web site, please take a moment to participate. Completion should only take a few minutes.

As our site is constantly changing, we would appreciate your input! We are listening... It is **your** feedback that makes those changes possible!

Thank you for taking the time to provide us with your comments! Remember, it is your feedback that makes changes possible in order to address your Medicare needs!



For Your Notes

Join the NHIC, Corp. DME MAC A ListServe!
Visit **http://www.medicarenhic.com/dme/listserve.html** today!

Helpful Contacts

Customer Service Telephone

Interactive Voice Response (IVR) System: 866-419-9458
Customer Service Representatives: 866-590-6731
TTY-TDD: 888-897-7539

Outreach & Education

outreach-education@hp.com

Claims Submissions

DME Jurisdiction A Claims
P.O. Box 9165
Hingham, MA 02043-9165

DME - ADS
P.O. Box 9170
Hingham, MA 02043-9170

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
Written Inquiry FAX: 781-741-3118

DME - MSP Correspondence
P.O. Box 9175
Hingham, MA 02043-9175

Overpayments

Refund Checks:
NHIC, Corp.
P.O. Box 809252
Chicago, IL 60680-9252

Payment Offset Fax Requests: 781-741-3916

Note: I*nclude 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

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:
NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:
Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

Customer Service should be your first means of contact for any questions or issues you have that cannot be addressed by the IVR. To speak with a Customer Service Representative directly call: 866-590-6731

DME MAC Jurisdiction A Resource

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

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Publication Information

NHIC, Corp. is the contractor for the Jurisdiction A DME MAC serving all of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Visit the following websites for more information:

NHIC, Corp.: **http://www.medicarenhic.com/dme**

TriCenturion: **http://www.tricenturion.com**

CMS: **http://www.cms.gov**

The *DME MAC Jurisdiction A Resource*, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

DME MAC Jurisdiction A Resource Coordinator
Outreach & Education Publications
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
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