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

MLN Matters® Number: MM8858
Related CR Release Date: February 24, 2015
Related CR Transmittal #: R1472OTN

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

Note: *This article was revised on February 27, 2015, to reflect the revised CR8858, issued on February 24. In the article, the CR release date, transmittal number, and the Web address for accessing CR8858 are revised. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

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

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.

- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional Information

The official instruction, CR8858 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1472OTN.pdf** on the CMS website.
The EDI help desk numbers are available at **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Downloads/EDIHelplines.pdf** on the CMS website.

International Classification of Diseases, Tenth Revision (ICD-10) Limited End to End Testing with Submitters for 2015 (MM8867) (GEN)

MLN Matters® Number: MM8867 **Related Change Request (CR) #: CR 8867**

Related CR Release Date: January 20, 2015 **Related CR Transmittal #: R1451OTN**

EFFECTIVE DATES: September 12, 2014 - for MACs and CEDI (non-systems change requirements) (Note: This is the due date of the first MAC and CEDI requirement); January 26, 2015 - for FISS and CEDI coding for January Testing Week; April 27, 2015 - for FISS and CEDI coding for April Testing Week; July 20, 2015 - for FISS and CEDI coding for July Testing Week.

IMPLEMENTATION DATES: January 5, 2015 - for FISS and CEDI coding for January Testing Week; February 16, 2015 - for MAC requirements for the January 15 testing. This is the due date of the last MAC deliverable.; April 6, 2015 - for FISS and CEDI coding for April Testing Week; May 18, 2015 - for MAC requirements for the April 15 testing. This is the due date of the last MAC deliverable.; July 6, 2015 - for FISS and CEDI coding for July Testing Week; August 10, 2015 - for MAC requirements for the July 15 testing. This is the due date of the last MAC deliverable.

Provider Types Affected

This MLN Matters® Article is intended for providers and clearinghouses wishing to submit test claims with ICD-10 codes to Medicare Administrative Contractors (MACs).

What You Need to Know

Change Request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to ICD-10. The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

Background

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

General Information

CR8867 will allow a small subset of submitters to test with MACs and the Common Electronic Data Interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited End-to-End testing weeks with a small subset of submitters.

To facilitate this testing, CR8867 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. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.

- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
    - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
    - MACs and CEDIs will post the form to their website by March 13, 2015, for the July 2015 testing.
    - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.

- By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set);
    - What dates of service may be used for testing;
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
    - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);
    - Notice that if more than 50 claims are submitted, they may not be processed;
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
    - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).

- MACs and CEDIs (for the DME MACs) will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the Health Insurance Claim Numbers (HICNs), Provider Transaction Access Number (PTANs), and National Provider Identifiers (NPIs) the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.

- Testers selected in the January 2015 Testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.

- Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language provided by CMS.

- MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.

- MACs and CEDI will instruct the testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.

- CEDI will instruct suppliers to submit claims with ICD-10 code with Dates of Service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with Dates of Service before October 1, 2015.
    - MACs will instruct testers to submit test claims with ICD-10 code with Dates of Service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with Dates of Service before October 1, 2015.
    - MACs and CEDIs will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.
    - MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.
    - MACs and CEDIs will post an announcement about the testing to their websites. The announcement will be provided by CMS.

Additional Information

The official instruction, CR8867 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1451OTN.pdf** on the CMS website.

You may also want to review MLN Matters® Article SE1409, which discusses ICD-10 testing. That article is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number, as well as your MAC's website address, 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) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492 (SE1408) (GEN)

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

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

Note: *This article was revised on February 20, 2015, to add a question and answer at the bottom of page 2 regarding dual processing of ICD-9 and ICD-10 codes. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the *Health Insurance Portability and Accountability Act* (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2015, implementation date.** Make sure your billing and coding staffs are aware of these changes.

Key Points of SE1408

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis

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

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

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

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

Claims that Span the ICD-10 Implementation Date

CMS has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A - Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (*incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs*)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	**THROUGH**
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	**THROUGH**
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	**THROUGH**
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	**THROUGH**
3X2	Home Health - Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	***See Note**
34X	Home Health - (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
73X	Federally Qualified Health Clinics *(prior to 4/1/10)*	N/A - Always ICD-9 code set.	**N/A**
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
77X	Federally Qualified Health Clinics *(effective 4/4/10)*	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
82X	Hospice - Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**
83X	Hospice - Hospital Based	N/A	**N/A**
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	**FROM**

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	**THROUGH**

Table C - Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.	**FROM**

Table D -Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).	**FROM**

Additional Information

You may also want to review SE1239 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf** on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf on the CMS website.

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

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

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

Note: *This article was revised on December 8, 2014, to include the dates and some additional details for the three end-to-end testing periods.*

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://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html** on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and *MS-DRG Definitions Manual* that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

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

Acknowledgement Testing

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

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

FAQs - International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing (SE1435) (GEN)

MLN Matters® Number: SE1435 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on December 24, 2014, to add FAQs 6-8 on page 3 and the former FAQ 6 is now FAQ 9. All other information remains the same.*

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to Know Prior to Testing

1. **How is ICD-10 end-to-end testing different from acknowledgement testing?**
   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. **What constitutes a testing slot for this testing?**
   A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. **What data must I provide to the MAC before testing?**
   For each testing slot, you must provide the MAC: up to 2 submitter identifiers (IDs), up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and up to 10 Health Insurance Claim Numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

   If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

4. **What should I consider when choosing HICNs for testing?**
   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. **If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?**
   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. **Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?**
   A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

7. **Do you have information on who has been selected for the January 2015 end-to-end testing?**
   We will release this information as part of the public release of our January test results.

8. **When do you expect to publically release results of the first round of end-to-end testing?**
   We expect to publically release results of the first round of end-to-end testing around the end of February 2015.

9. **Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?**
   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to Know During Testing

1. **Is it safe to submit test claims with Protected Health Information (PHI)?**
   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. **What Dates of Service can be used on test claims?**
   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

   Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. **Can both ICD-9 and ICD-10 codes be submitted on the same claim?**
   ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to MLN Matters® Article SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date" located at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf** on the Centers for Medicare & Medicaid Services website.

4. **Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?**
   Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare Administrative Contractor (MAC) for further information.

   Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. **If a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?**
   If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

   If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

   If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. **For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?**
   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

7. **For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?**
   You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

8. **For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?**
   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required. You do not need to submit the supporting data sheets.

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.

FAQs - International Classification of Diseases, 10th Edition (ICD-10) Acknowledgement Testing and End-to-End Testing (SE1501) (GEN)

MLN Matters® Number: SE1501
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies who participate in Medicare ICD-10 acknowledgement testing and who are selected to participate in end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. When "you" is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

Question	Acknowledgement Testing	End-to-End Testing
Do I need to register for testing?	No, you do not need to register for acknowledgement testing.	Yes, end-to-end testing volunteers must register on their Medicare Administrative Contractor (MAC) website during specific time periods.
Who can participate in testing?	Acknowledgement testing is open to all Medicare Fee-For-Service (FFS) electronic submitters.	End-to-end testing is open to: • Medicare FFS direct submitters; • Direct Data Entry (DDE) submitters who receive an Electronic Remittance Advice (ERA); • Clearinghouses; and • Billing agencies.
How many testers will be selected?	All Medicare FFS electronic submitters can acknowledgement test.	50 end-to-end testers will be selected per MAC jurisdiction for each testing round. **You must be selected by the MAC for this testing.**
What will the testing show?	The goal of acknowledgement testing is to demonstrate that: • Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes; • Providers submitted claims with valid National Provider Identifiers (NPIs) • The claims are accepted by the Medicare FFS claims systems; and • Claims receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.	The goal of end-to-end testing is to demonstrate that: • Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems; • Software changes the Centers for Medicare & Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and • Accurate Remittance Advices are produced.
Will the testing test National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)?	No, acknowledgment testing will not test NCDs and LCDs.	Yes, end-to-end test claims will be subject to all NCDs and LCDs.
Will the testing confirm payment and return an ERA to the tester?	No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.	Yes, end-to-end testing will provide an ERA based on current year pricing.

Question	Acknowledgement Testing	End-to-End Testing
How many claims can testers submit?	There is no limit on the number of acknowledgement test claims you can submit.	You may submit 50 end-to-end test claims per test week.
How do testers submit claims for testing?	You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator "T" in the Interchange Control Structure (ISA) 15 field.	You submit end-to-end test claims directly with test indicator "T" in the ISA15 field or through DDE.
When should testers submit test claims?	You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks: • March 2 - 6, 2015; and • June 1 - 5, 2015.	You must submit end-to-end test claims during the following testing weeks: • January 26 - 30, 2015; • April 27 - May 1, 2015; and • July 20 - 24, 2015.
What dates of service do testers use during testing?	You must use current dates of service during acknowledgement testing.	You must use the following future dates of service during end-to-end testing: • Professional claims - Dates of service on or after October 1, 2015; • Inpatient claims - Discharge dates on or after October 1, 2015; • Supplier claims - Dates of service between October 1, 2015, and • October 15, 2015; and • Professional and institutional claims - Dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

Important Note: *Remember that you must be selected by the MAC in order to participate in end-to-end testing.*

RESOURCES

The chart below provides ICD-10 resource information.

For More Information About…	Resource
ICD-10	**http://www.cms.gov/Medicare/Coding/ICD10/index.html** on the CMS website
ICD-10 Information for Medicare Fee-For-Service Providers	**http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html** on the CMS website
ICD-10 Implementation Timelines	**http://www.cms.gov/Medicare/Coding/ICD10/CMSImplementationPlanning.html** on the CMS website
ICD-10 Statute and Regulations	**http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html** on the CMS website
All Available Medicare Learning Network® (MLN) Products	"Medicare Learning Network® Catalog of Products" located on the CMS website or scan the Quick Response (QR) code on the right
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" located at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf** on the CMS website
Medicare Information for Patients	**http://www.medicare.gov** on the CMS 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

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2015 Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List (MM9018) (GEN)

MLN Matters® Number: MM 9018
Related CR Release Date: December 12, 2014
Related CR Transmittal #: R3148CP

Related Change Request (CR) #: CR 9018
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9018 notifies suppliers that the spreadsheet containing an updated list of Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC or MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the "*Medicare Claims Processing Manual*" are reflected in the recurring update notification.

The spreadsheet for the 2015 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at **http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html** on the Centers for Medicare & Medicaid Services (CMS) website. The spreadsheet is also attached to CR9018.

Additional Information

The official instruction for CR9018 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3148CP.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?

Claim Status Category and Claim Status Codes Update (MM8994) (GEN)

MLN Matters® Number: MM8994
Related CR Release Date: December 5, 2014
Related CR Transmittal #: R3143CP

Related Change Request (CR) #: CR 8994
Effective Date: April 1, 2015
Implementation Date: April 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) 8994 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staff are aware of these changes.

Background

The *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) requires all health care payers 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 format adopted as the standard for National use under HIPAA. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January, June, and October) and makes decisions about additions of new codes, as well as 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.

These pages have previously been referenced at **http://www.wpc-edi.com/codes** on the Internet. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2015 committee meeting shall be posted on the previously mentioned websites on or about February 1, 2015. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all ASC X12 276 transactions processed on or after the date of implementation and are to be reflected in ASC X12 277 transactions issued on and after the date of implementation of CR 8994.

Additional Information

The official instruction, CR 8994 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3143CP.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.

Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP): Additional Instructions for Grandfathered Items Subject to CBP (MM9060) (GEN)

MLN Matters® Number: MM9060
Related CR Release Date: February 13, 2015
Related CR Transmittal #: R1470OTN

Related Change Request (CR) #: CR 9060
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 grandfathered DMEPOS items provided to Medicare beneficiaries under the competitive bidding program.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9060 to make certain that your DME MACs adjust their systems as necessary to process and pay claims from grandfathered DME suppliers for certain items subject to the CBP, including capped rental items, and oxygen supply items. Make certain your billing staffs are aware of these changes.

Background

The DMEPOS Competitive Bidding Program (CBP) 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, CMS conducts a competition among suppliers who operate in a particular Competitive Bidding Area (CBA). 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 following policies detail the CR9050 instructions for grandfathered DME items:

Accessories for Capped Rental Items

A grandfathered supplier with claims for accessories with a date of service during the rental period of the grandfathered equipment is entitled to payment at the single payment amount regardless the status of the Certificate of Medical Necessity (CMN) when the claim is submitted (provided timely filing requirements are met). DME MACs will make changes in order to pay in accordance with this policy.

Advance Beneficiary Notice (ABN)

If an Original Medicare beneficiary living in a CBA opts to receive their competitively bid items and supplies from a non-contract supplier, they can indicate that preference by signing an ABN. The DME MAC should allow the claims to process, but deny the with a Patient Responsibility (PR) group code so the beneficiary is financially responsible for the claim.

The GA modifier indicates that the beneficiary has signed an ABN for the item or supply.
The following remark and reason codes will be used when denying a claim for a competitive bid item obtained from a non-contract supplier, when the supplier has obtained an ABN from the beneficiary:

- N211: Alert: You may not appeal this decision.;
- 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.; and
- M38: The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.

Group Code: PR - Patient Responsibility

Grandfathering: Changing Locations

Medicare allows a new 13-month capped rental period when a beneficiary receiving a capped rental item from a grandfathered supplier elects to transition to a contract supplier prior to the 13th month of rental. Medicare also allows a contract supplier to receive 10 monthly rental payments if a beneficiary receiving oxygen items from a grandfathered supplier elects to transition to a contract supplier prior to the 36th month of rental but after the 27th month of rental. If the 10 monthly rental payments are not complete prior to the end of the round and the beneficiary elects to switch again to a new contract supplier for the subsequent round, the new contract supplier will be paid the remainder of the 10 monthly rental payments. The additional payments are not payable if a beneficiary switches from a contract supplier to another contract supplier. The additional payments are payable if a beneficiary switches from a non-contract supplier (grandfathered) to a contract supplier even if it occurs between rounds.

Contract suppliers may designate certain locations as contract supplier locations and other locations that serve as a non-contract grandfather location. In any grandfathering situation, when a beneficiary switches from a grandfathered supplier (non-contract) location to a contracted location of the same or related supplier that contract supplier is not entitled to the additional payments. Simply changing the location that was furnishing the grandfathered item to a contracted location of a related supplier does not entitle the contracted supplier to additional payments.

Processing Grandfathering Claims at the 6-Digit Provider Transaction Access Number (PTAN) Level

Currently, if a non-contracted supplier provides a competitive bid item to a competitive bid beneficiary as a grandfathered supplier and then transitions the beneficiary to another related non-contracted location (that is, both locations share the same Employee Identification number and the first six-digits of their PTAN), the new location would be eligible for payment as a grandfathered supplier. Medicare's claims processing system needs to allow for payment if there is a match between the billing supplier and the supplier on the CMN at the six-digit PTAN level as opposed to the 10-digit PTAN. Once the system is updated, a related location of the grandfathered supplier can receive payment for the equipment's remaining rental months in place of the original grandfathered supplier.

Determining the Appropriate Payment Amount for a Grandfathered Item

Payment for grandfathered items is dependent upon whether or not the item was previously included in a competitive bidding round. In order to correctly determine the payment amount for grandfathered items, Medicare's claims processing system needs to identify grandfathered claims using a combination of ZIP Code and HCPCS code. Currently, that system identifies grandfathered claims by CBA, HCPCS code, and HCPCS modifier which can cause processing errors if the identifier used for the CBA changes (from one round to another) or if a HCPCS modifier requirements change.

Additional Information

The official instruction for CR9060 issued to your DME MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1470OTN.pdf** on the CMS website.

"*The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers*" should be review at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Grandfathering_Factsheet_ICN900923.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?

Healthcare Provider Taxonomy Codes (HPTCs) April 2015 Code Set Update (MM8993) (GEN)

MLN Matters® Number: MM8993
Related CR Release Date: February 20, 2015
Related CR Transmittal #: R3201CP

Related Change Request (CR) #: CR 8993
Effective Date: April 1, 2015
Implementation Date: As soon as April 1, 2015, but no later than 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), including Home Health and Hospice MACs and Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8993 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.
You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 8993 implements the NUCC HPTC code set that is effective on April 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at **http://www.wpc-edi.com/codes** on the Internet.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

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

Additional Information

The official instruction, CR 8993, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3201CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 (MM8901) (GEN)

MLN Matters® Number: MM8901
Related CR Release Date: December 12, 2014
Related CR Transmittal #: R561PI

Related Change Request (CR) #: CR 8901
Effective Date: March 18, 2015
Implementation Date: March 18, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8901 incorporates into Chapter 15 of the "*Program Integrity Manual*" (PIM) several provider enrollment policies in the final rule titled, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs."

Key Points of CR8901

The key points of the updated Chapter 15 of the "*Medicare Program Integrity Manual*" are as follows:

- If a MAC approves a provider's or supplier's Form CMS-855 reactivation application or Reactivation Certification Package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new Provider Transaction Access Number (PTAN).

- CMS may deny a physician's or eligible professional's Form CMS-855 enrollment application under § 424.530(a)(11) if:
  - The physician's or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(13) if:
  - The physician's or eligible professional's DEA Certificate of Registration is suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs.

- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:
  - The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
  - The pattern or practice of prescribing fails to meet Medicare requirements.

Additional Information

The official instruction, CR8901, issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R561PI.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.

New Timeframe for Response to Additional Documentation Requests (MM8583) (GEN)

MLN Matters® Number: MM8583
Related CR Release Date: February 4, 2015
Related CR Transmittal #: R567PI

Revised Related Change Request (CR) #: CR 8583
Effective Date: April 1, 2015
Implementation Date: April 6, 2015

Note: *This article was revised on February 9, 2015, to reflect the revised CR8583 issued on February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.*

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The *Social Security Act*, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the "*Medicare Program Integrity Manual*," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions),when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

Additional Information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R567PI.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

Payment Repairs to Capped Rental Equipment Prior to the End of the 13- Month Cap (MM9062) (GEN)

MLN Matters® Number: MM 9062
Related CR Release Date: February 13, 2015
Related CR Transmittal #: R203BP and R3196CP
Related Change Request (CR) #: CR 9062
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9062 alerts suppliers and DME MACs that reasonable and necessary charges for maintenance and servicing of beneficiary-owned DME will be made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty and where the supplier transfers title to the beneficiary prior to the end of the 13 month period of continuous use. CR9062 supplements CR7212 that did not account for situations in which the title of the item is transferred to the beneficiary prior to the end of the 13 month rental period. Make sure your billing staffs are aware of these changes.

Background

CR9062 instructs the DME MACs to ensure editing occurs on all payments for reasonable and necessary maintenance and servicing of capped rental items in cases where one or more rental payments have been made for a capped rental item and the supplier transfers the title to the equipment to the beneficiary prior to the end of a 13 month period of continuous use.

Transmittal 901, CR7212 issued on May 27, 2011 "Edit to Deny Claims for Repairs to Capped Rental Durable Medical Equipment (DME)" established billing procedures for payment for all maintenance, servicing and repairs of capped rental DME included in the allowed rental payment amounts. For equipment furnished on a rental basis no separate payment may be made for these services prior to the end of the 13-month capped rental period.

Medicare payment can be made for repairs of the equipment after the transfer of title if the DME MAC determines that the repairs are reasonable and necessary in accordance with Medicare regulations and program instructions.

Key Points of CR9062

Your DME MAC will:

1. Process claims for replacement parts furnished in conjunction with the repair of a capped rental items that are billed with the RB modifier, including claims for the parts that are billed during the capped rental period if there is evidence that the supplier has transferred the title of the capped rental item to the beneficiary;
2. Process and pay claims for reasonable and necessary repairs that are billed with the HCPCS code K0739 for the labor associated with the repairs to capped rentals items if there is evidence that the supplier has transferred the title of the capped rental item to the beneficiary.

Note that an attestation of warranty transfer (be it a copy of the warranty or a signed/dated statement from the beneficiary verifying transfer) must be kept on file at the supplier submitting the claim, and available to be submitted upon request.

In cases where one or more monthly rental payments have been made in accordance with 42 CFR 414.229 for a capped rental DME item, medical necessity for the equipment has been established. In cases where one or more rental payments have been made for an item classified as capped rental DME, and the supplier transfers the title of the equipment prior to the end of a 13 month period of continuous use per 42 CFR 414.230, Medicare payment is made for reasonable and necessary maintenance and servicing of the beneficiary-owned DME. Under the regulations at 42 CFR 414.210(e)(1), reasonable and necessary charges for maintenance and servicing are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. Charges for routine maintenance and servicing would not be covered. Charges for maintenance and servicing that exceed the purchase price of the equipment (i.e., the capped rental monthly fee multiplied by 10) would not be reasonable and necessary and should be denied.

In the case of a manufacturer or supplier warranty, if the DME MAC can confirm that the manufacturer or supplier is no longer in business and the warranty that the manufacturer or supplier previously offered is no longer in effect for the item of capped rental equipment, DME MACs will allow the charges for replacement parts and labor related to maintenance and servicing of beneficiary-owned equipment, if otherwise reasonable and necessary, in accordance with the above requirements.

In the case of a manufacturer or supplier warranty, if the DME MAC can confirm that the manufacturer or supplier is still in business and there is a warranty in effect for the capped rental item, then the DME MAC will deny claims for replacement parts and labor furnished in conjunction with the repair of a capped rental item. Your DME MAC will use the following group code and messages, when denying claims for replacement parts and labor:

- Group Code - Contractual Obligation (CO) 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **NOTE:** refer to the 835 healthcare policy identification segment (loop 2110 service payment information ref), if present.
- MA 13: Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- N211 Alert: You may not appeal this decision.

In addition, the DME MACs will close the Certificate of Medical Necessity (CMN) as a purchase when there is evidence that the supplier has transferred the title of a capped rental item to a beneficiary.

Additional Information

CR9062 consists of two transmittals. The first updates the "*Medicare Benefit Policy Manual*" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R203BP.pdf** on the CMS website.
The second updated the "*Medicare Claims Processing Manual*" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3196CP.pdf** on the CMS website.

To review MM7212 Edit to Deny Claims for Repairs to Capped Rental Durable Medical Equipment (DME) go to: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7212.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?

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM9004) (GEN)

MLN Matters® Number: MM9004
Related CR Release Date: January 9, 2015
Related CR Transmittal #: R3161CP

Related Change Request (CR) #: CR 9004
Effective Date: April 1, 2015
Implementation Date: April 6, 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.

Provider Action Needed

Change Request (CR) 9004 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists that are effective April 1, 2015. The CR 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 for 2015 and that they 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 that 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 on Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9004, 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.

CR9004 lists only the changes that have been approved since the last code update CR (CR8855, Transmittal 2996, issued on July 25, 2014, with a related MLN Matters® article available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.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

Changes in CARC List since CR8855

These are changes in the CARC database since the last code update in CR8855.

Code Current Narrative Effective Date 262 Adjustment for delivery cost. Note: To be used for pharmaceuticals only. 11/1/2014 263 Adjustment for shipping cost. Note: To be used for pharmaceuticals only. 11/1/2014 264 Adjustment for postage cost. Note: To be used for pharmaceuticals only. 11/1/2014 265 Adjustment for administrative cost. Note: To be used for pharmaceuticals only. 11/1/2014 266

Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only. 11/1/2014 267 Claim spans multiple months. Rebill separate claim/service. 11/1/2014 268 Claim spans 2 calendar years. Please resubmit one claim per calendar year. 11/1/2014

New Codes - CARC:

Code	Current Narrative	Effective Date
262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.	11/1/2014
263	Adjustment for shipping cost. Note: To be used for pharmaceuticals only.	11/1/2014
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.	11/1/2014
265	Adjustment for administrative cost. Note: To be used for pharmaceuticals only.	11/1/2014
266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.	11/1/2014
267	Claim spans multiple months. Rebill separate claim/service.	11/1/2014
268	Claim spans 2 calendar years. Please resubmit one claim per calendar year.	11/1/2014

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: 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).	11/1/2014
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) 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.)	11/1/2014

Deactivated Codes - CARC - None

Changes in RARC List since CR8855

These are changes in the RARC database since the last code update CR 8855.

New Codes - RARC:

Code	Narrative	Effective Date
N729	Missing patient medical/dental record for this service.	11/1/2014
N730	Incomplete/invalid patient medical/dental record for this service.	11/1/2014
N731	Incomplete/Invalid mental health assessment.	11/1/2014
N732	Services performed at an unlicensed facility are not reimbursable.	11/1/2014
N733	Regulatory surcharges are paid directly to the state.	11/1/2014
N734	The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.	11/1/2014

Modified Codes - RARC:

Code	Modified Narrative	Effective Date
N42	Missing mental health assessment.	11/1/2014
MA118	Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.	11/1/2014
MA09	Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement.	11/1/2014

Deactivated Codes - RARC

Code	Current Narrative	Effective Date
N483	Missing Periodontal Charts	05/01/2015
N484	Incomplete/invalid Periodontal Charts.	5/1/2015

NOTE: *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.*

Additional Information

The official instruction, CR9004, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3161CP.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.

Reporting Force Balance Claim Payment on the Electronic Remittance Advice (ERA) 835 and Cross Over Beneficiary 837 Claim Transactions (GEN)

MLN Matters® Number: MM 9050
Related CR Release Date: February 13, 2015
Related CR Transmittal #: R1467OTN
Related Change Request (CR) #: CR 9050
Effective Date: July 1, 2015
Implementation Date: July 6, 2015

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued CR 9050 to alert providers that Claim Adjustment Reason Code (CARC) A7 will be replaced on July 1, 2015, by CARC 121 to report force balancing of Out of Balance (OOB) claims payment/adjudication.

Background

CR9050 modifies the way MACs report force balancing of OOB claim payment/adjudication. Currently, MACs are using CARC A7-Presumptive Payment Adjustment to report the balancing of OOB payments. CR9050 instructs MACs to use CARC 121-Indemnification adjustment- compensation for outstanding member responsibility in place of A7. This will be effective July 1, 2015. In addition, MACs will use Group Code OA (Other Adjustment) as the required Group Code.

Finally, MACs will report offsetting of Veterans Affairs claims at the provider level using PLB code J1 "Non-Reimbursable" and an offsetting dollar amount.

Additional Information

The official instruction for CR9050 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1467OTN.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?

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

MLN Matters® Number: MM8566 Revised
Related CR Release Date: December 5, 2014
Related CR Transmittal #: R1445OTN

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

Note: *This article was revised on December 9, 2014, to reflect the revised CR8566 issued on December 5. The CR was revised to add a caret (^) to code E2378 in the table in Attachment A of the CR denoting this is an item which can be billable with complex rehabilitative wheelchair codes K0835-K0864. In the article, the CR release date, transmittal number, and the Web address for accessing CR8566 are revised also. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

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

Background

DME and accessories used in conjunction with DME are paid for under the DME benefit and in accordance with the rules at section 1834(a) of the *Social Security Act* (the Act). The Medicare definition of routinely purchased durable medical equipment (DME) set forth at 42 CFR 414.220(a)(2) specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989, that is, new codes added to the HCPCS after 1989 for items costing more than $150, showed inconsistencies in applying the definition. As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. CMS-1526-F is available at **http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf** on the Internet.

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

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

Be aware the effective date is April 1, 2014 for HCPCS codes not included in a Competitive Bidding Program (CBP) as shown in Attachment A of CR8566. A forthcoming CR will address the codes that are reclassifying to the capped rental payment category effective July 1, 2016, and January 1, 2017. As shown in the table below, HCPCS codes for items included under the Round 2 and/or Round 1 Recompete DMEPOS CBPs will transition to the capped rental payment category in stages.

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

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

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

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

Complex Rehabilitative Power Wheelchair Accessories

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

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

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

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

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

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

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

Additional Information

The official instruction, CR 8566 along with Attachment A, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1445OTN.pdf** on the CMS website. Attachment A is also repeated at the end of this article.

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

Attachment A

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

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

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

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
	E2321 ^	Hand interface joystick	■		
	E2322 ^	Mult mech switches	■		
	E2325 ^	Sip and puff interface	■		
	E2326 ^	Breath tube kit	■		
	E2327 ^	Head control interface mech	■		
	E2328 ^	Head/extremity control interface	■		
	E2329 ^	Head control interface nonproportional	■		
	E2330 ^	Head control proximity switch	■		
	E2351 ^	Electronic SGD interface	■		
	E2368 *	Pwr wc drivewheel motor replace		■	■
	E2369 *	Pwr wc drivewheel gear box replace		■	■
	E2370 *	Pwr wc dr wh motor/gear comb		■	■
	E2373 ^	Hand/chin ctrl spec joystick	■		
	E2374 ^	Hand/chin ctrl std joystick	■		
	E2375 *	Non-expandable controller		■	■
	E2376 ^	Expandable controller, replace	■		
	E2377 ^	Expandable controller, initial	■		
	E2378 ^	Pw actuator replacement	■		
	K0015 *	Detach non-adjus hght armrest		■	■
	K0070 *	Rear whl complete pneum tire		■	■
Wheelchairs Seating	E0955 *	Cushioned headrest		■	■

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

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

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: February 13, 2015
Related CR Transmittal #: R1466OTN

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

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.

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/R1466OTN.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?

April 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9084) (DRU)

MLN Matters® Number: MM9084
Related CR Release Date: January 30, 2015
Related CR Transmittal #: R3180CP
Related Change Request (CR) #: CR 9084
Effective Date: April 1, 2015
Implementation Date: April 6, 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 MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9084 informs Medicare MACs to download and implement the April 2015 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 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 April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that 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); see **http://www.cms.gov/manuals/downloads/clm104c04.pdf** on the CMS website.)

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

Files	Effective Dates of Service
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
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014

NOTE: The absence or presence of a Healthcare Common Procedure Coding System (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, CR 9084 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3180CP.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.

Calendar Year (CY) 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM8999) (GEN)

MLN Matters® Number: MM8999
Related CR Release Date: February 6, 2015
Related CR Transmittal #: R3190CP

Revised Related Change Request (CR) #: CR 8999
Effective Date: January 1, 2015
Implementation Date: January 5, 2015

Note: *This article was revised on February 24, 2015, to reflect the revised CR8999 issued on February 6. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were updated. 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

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8999 to advise providers of the CY 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the "*Medicare Claims Processing Manual*," Chapter 23, Section 60, which is available at

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the *Social Security Act* (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

Key Points

Fee Schedule Files

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

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

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category;
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.); and
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are in the table below.

Factor	Category
0.459	Oxygen
0.462	Capped Rental
0.464	Prosthetics and Orthotics
0.588	Surgical Dressings
0.640	Parenteral and Enteral Nutrition
0.963	Intraocular Lenses
0.980	Splints and Casts

Specific Coding and Pricing Issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the *American Taxpayer Relief Act* of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to

the single payment amounts for mail order DTS established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR8204, dated February 22, 2013. The MLN Matters® article related to CR8204 is available at
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf on the CMS website.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.5 percent for CY 2015. The single payment amount public use file for the national mail order competitive bidding program is available at
http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

2015 Fee Schedule Update Factor of 1.5 Percent

For CY 2015, the update factor of 1.5 percent is applied to the applicable CY 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 Update to the Labor Payment Rates

The table below contains the CY 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for CY 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

STATE	K0739	L4205	L7520
NC	$14.86	$22.14	$30.05
ND	18.51	31.81	37.50
NE	14.86	22.11	41.90
NH	15.95	22.11	30.05
NJ	20.04	22.11	30.05
NM	14.86	22.14	30.05
NV	23.67	22.11	40.96
NY	27.35	22.14	30.05
OH	14.86	22.11	30.05
OK	14.86	22.14	30.05
OR	14.86	22.11	43.21
PA	15.95	22.77	30.05
PR	14.86	22.14	30.05
RI	17.70	22.79	30.05
SC	14.86	22.14	30.05
SD	16.60	22.11	40.18
TN	14.86	22.14	30.05
TX	14.86	22.14	30.05
UT	14.90	22.11	46.79

STATE	K0739	L4205	L7520
AK	$27.98	$31.88	$37.50
AL	14.86	22.14	30.05
AR	14.86	22.14	30.05
AZ	18.37	22.11	36.97
CA	22.79	36.34	42.35
CO	14.86	22.14	30.05
CT	24.81	22.63	30.05
DC	14.86	22.11	30.05
DE	27.35	22.11	30.05
FL	14.86	22.14	30.05
GA	14.86	22.14	30.05
HI	18.37	31.88	37.50
IA	14.86	22.11	35.97
ID	14.86	22.11	30.05
IL	14.86	22.11	30.05
IN	14.86	22.11	30.05
KS	14.86	22.11	37.50
KY	14.86	28.34	38.43
LA	14.86	22.14	30.05

STATE	K0739	L4205	L7520
VA	14.86	22.11	30.05
VI	14.86	22.14	30.05
VT	15.95	22.11	30.05
WA	23.67	32.44	38.53
WI	14.86	22.11	30.05
WV	14.86	22.11	30.05
WY	20.71	29.50	41.90
WY	20.71	29.50	41.90

STATE	K0739	L4205	L7520
MA	24.81	22.11	30.05
MD	14.86	22.11	30.05
ME	24.81	22.11	30.05
MI	14.86	22.11	30.05
MN	14.86	22.11	30.05
MO	14.86	22.11	30.05
MS	14.86	22.14	30.05
MT	14.86	22.11	37.50

2015 National Monthly Payment Amounts for Stationary Oxygen Equipment

As part of CR8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

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

2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR6792, dated February 5, 2010, (see the article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf**) and Transmittal 717, CR6990, dated June 8, 2010, (see the related article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf**).

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

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to Change Request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional Information

The official instruction for CR8999 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3190CP.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?

2015 Fees for Repairs/Labor (CR8999) (GEN)

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

The below table identifies the 2015 fee schedule for K0739, L4205, L7520 for dates of service on or after January 01, 2015, through December 31, 2015.

STATE	K0739	L4205	L7520
CT	24.81	22.63	30.05
DC	14.86	22.11	30.05
DE	27.35	22.11	30.05
MA	24.81	22.11	30.05
MD	14.86	22.11	30.05
ME	24.81	22.11	30.05
NH	15.95	22.11	30.05
NJ	20.04	22.11	30.05
NY	27.35	22.14	30.05
PA	15.95	22.77	30.05
RI	17.70	22.79	30.05
VT	15.95	22.11	30.05

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, **http://www.medicarenhic.com/dme/dmfees.aspx**.
This quarter the following notices have been posted:

- 1st Quarter 2015 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2015 Oral Anticancer Drug Fees
- 2nd Quarter 2014 Average Sales Price Medicare Part B Drug Pricing File
- 3rd 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 product from the Medicare Learning Network® (MLN)

- "**Complying With Medical Record Documentation Requirements**" Fact Sheet, ICN 909160, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf**

Revised products from the Medicare Learning Network® (MLN)

- "**Medicare Secondary Payer Provisions**" Web-based Training (WBT)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
- "**Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians**" Web-based Training (WBT)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
- "**Safeguarding Your Medical Identity**" Web-based Training (WBT)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
- "**ICD-10-CM/PCS Billing and Payment Frequently Asked Questions**" Fact Sheet (ICN 908974), Hard Copy.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/September-2013-ICD-10-CM-PCS-Billing-Payment-FAQs-Fact-Sheet-ICN908974.pdf
- "**The DMEPOS Competitive Bidding Program: Non-Contract Supplier**", Fact Sheet, ICN 900925, downloadable
  http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME-Noncontract-Factsheet-ICN900925.pdf

MLN Matters® Articles Index

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

Seasonal Flu Vaccinations

Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit **MLN Matters® Article MM8890**, (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8890.pdf**) "*Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season*" and **MLN Matters® Article SE1431** **(http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1431.pdf)**, "*2014-2015 Influenza (Flu) Resources for Health Care Professionals*."

While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community. The **HealthMap Vaccine Finder** (**http://vaccine.healthmap.org/admin/signup/**) is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, **register** (**http://vaccine.healthmap.org/admin/signup/**) for an account to submit your information in the database. Also, visit the **CDC Influenza (Flu)** (**http://www.cdc.gov/FLU/**) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

Get Your Patients Off to a Healthy Start in 2015 with the Medicare Annual Wellness Visit

A yearly office visit that focuses on preventive health, and the Initial Preventive Physical Examination, commonly known as the "Welcome to Medicare" Preventive Visit - a one-time service for newly-enrolled beneficiaries. **Read more**.
http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Mesages-New-Items/2015-01-08-AWV-IPPE.html

DMEPOS Electronic Mailing List

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**" (**https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814**) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

Stay Connected

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

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

Subscribe (**https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819**) to the MLN Connects™ Provider eNews: a weekly electronic publication with the latest Medicare program information, including MLN Connects™ National Provider Call announcements, claim and pricer information, and Medicare Learning Network® educational product updates.

MLN Connects® Provider eNews (GEN)

MLN Connects® Provider eNews for December 4, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-12-04-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-12-04-eNews.pdf

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes - Last Chance to Register
- Certifying Patients for the Medicare Home Health Benefit - Register Now

MLN Connects® Videos

- Monthly Spotlight: Physician Feedback Program/Value-based Payment Modifier

CMS Events

- Webinar for Comparative Billing Report on Modifier 25: Family Practice

Announcements

- National Influenza Vaccination Week - December 7-13
- CMS Releases New Proposal to Improve Accountable Care Organizations
- Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms, 50,000 Lives Saved and $12 Billion in Health Spending Avoided
- Provider Enrollment Application Fee Amount for CY 2015

- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- ICD-10 MS-DRGs v32 Software Now Available
- Inpatient PPS FY 2014.8 PC Pricer Updated
- Clarification of Specialty Care Transport Payment Policy for Ambulance Transportation Services

Medicare Learning Network® Educational Products

- "*Affordable Care Act* Provider Compliance Programs: Getting Started" Web-Based Training Course - Released
- "Complying With Medical Record Documentation Requirements" Fact Sheet - Released
- "Hospital Reclassifications" Fact Sheet - Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for December 11, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-12-11-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-12-11-eNews.pdf

MLN Connects® National Provider Calls

- Certifying Patients for the Medicare Home Health Benefit - Last Chance to Register
- ESRD QIP Payment Years 2017 and 2018 Final Rule - Registration Opening Soon

MLN Connects® Videos

- Coding for ICD-10-CM: More of the Basics

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April - Registration Opening Soon
- QRDA I and III Submissions for Eligible Professionals eHealth Provider Webinar
- Physician Compare Virtual Office Hour Session

Announcements

- New CMS Rules Enhance Medicare Provider Oversight; Strengthens Beneficiary Protections
- New Requirements for Prescribers of Medicare Part D Drugs
- ESRD PPS Low-Volume Payment Adjustment: Act by December 31
- Eligible Hospitals Must Attest By December 31 to Receive 2014 EHR Incentive
- Financial Incentives and Ability to Exchange Clinical Information Found to be Top Reasons for EHR Adoption
- HHS Awards $36.3 Million in *Affordable Care Act* Funding to Reward and Expand Quality Improvement in Health Centers
- See the Big Picture with Open Payments Search Tool Enhancements
- Contractor Assists Hospitals in Reporting Inpatient Quality Data
- Updates to IRIS Software
- Access Your 2013 QRUR
- 2012 Supplemental QRURs Available to Group Practices
- EHR Incentive Programs: Protect Electronic Health Information Core Objective
- Get Ready Now for ICD-10

Claims, Pricers, and Codes

- January 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article - Revised
- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters® Article - Revised

- "Skilled Nursing Facility Billing Reference" Fact Sheet - Revised
- The Basics of Internet-based PECOS for DMEPOS Suppliers" Fact Sheet - Reminder
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Products Available In Electronic Publication Format
- Submit Your Feedback on the Medicare Learning Network® Learning Management System and Product Ordering System

MLN Connects® Provider eNews for December 18, 2014

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2014-12-18-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-12-18-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process - Registration Opening Soon
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 - Registration Now Open
- ESRD QIP Payment Year 2017 and 2018 Final Rule - Registration Now Open
- New MLN Connects® National Provider Call Video Slideshow, Audio Recording, and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April - Forms Due January 9

Announcements

- CDC Continues to Recommend a Flu Vaccine as the Best Way to Protect Against the Flu
- Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage Overview
- HIS Data Collection for FY 2016 Annual Payment Update Ends December 31
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- Frequently Asked Questions on DMEPOS 2015 Medicare Payment Final Rule
- Open Payments: Final Rule Changes Related to Continuing Education Events
- Comparative Billing Report on Modifier 59: Dermatology

Claims, Pricers, and Codes

Reprocessing of IPPS Claims Assigned to DRG 410, 573 or 907

Medicare Learning Network® Educational Products

- "FAQs - International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article - Released
- "Medical Privacy of Protected Health Information" Fact Sheet - Revised
- Medicare Learning Network Products® Available In Electronic Publication Format

MLN Connects® Provider eNews for January 08, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-01-08-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-01-08-eNews.pdf

MLN Connects® National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process - Last Chance to Register
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 - Last Chance to Register
- ESRD QIP Payment Year 2017 and 2018 Final Rule - Register Now
- New MLN Connects® National Provider Call Audio Recordings and Transcripts
- Continuing Education for Participation in MLN Connects® National Provider Calls

MLN Connects® Videos

- Monthly Spotlight: The 2-Midnight Benchmark Rule

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April - Deadline Extended to January 21
- Open Payments Question & Answer Session
- Physician Compare Virtual Office Hour Session
- ICD-10 Clinical Documentation Improvement Webinar Recording Available

Announcements

- Get Your Patients Off to a Healthy Start in 2015 with the AWV and the IPPE
- Public Reporting of 2013 Quality Measures on the Physician Compare and Hospital Compare Websites
- FY 2015 Results for the HAC Reduction Program and Hospital VBP Program
- ACOs Moving Ahead: New Participants in Medicare Shared Savings Program
- CMS Updates Open Payments Data
- Open Payments System Unavailable in January
- January Quarterly Provider Update Available
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the *Affordable Care Act*
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hospice Claims Returned in Error for Edit U5181
- Part A Claims Hold for Select Preventive and Screening Services

Medicare Learning Network® Educational Products

- "Certifying Patients for the Medicare Home Health Benefit" MLN Matters® Article - Released
- "Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" MLN Matters® Article - Released
- "The 2013 Physician Quality Reporting System (PQRS)" Booklet - Released
- "FAQs - International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article - Revised
- "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet - Revised
- "Discharge Planning" Booklet - Revised
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet - Reminder
- "The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet - Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects® Provider eNews for January 15, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-01-15-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-01-15-Enews.pdf

Editor's Note
Thank you for providing feedback about the MLN Connects® Provider eNews in 2014. We take your feedback seriously and have used it to enhance the eNews throughout the year. It is easier than ever to give us feedback on your eNews experience in 2015. Please continue to let us know how the eNews is helping you or provide us any suggestions you may have. Have a great year.

MLN Connects® National Provider Calls

- ESRD QIP Payment Year 2017 and 2018 Final Rule - Last Chance to Register

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April - Forms Due January 21
- Webinar for Comparative Billing Report on Modifier 59: Dermatology
- Open Payments Program Overview Video Tutorial Now Available

Announcements

- Help Protect the Vision of Your Medicare Patients - Recommend Annual Glaucoma Screening
- Hospice Providers: Continue to Collect and Submit HIS Data in 2015
- Open Payments System Unavailable through Late January

Claims, Pricers, and Codes

- Adjustment of Some Home Health Claims: Update

Medicare Learning Network® Educational Products

- "FAQs - International Classification of Diseases, 10th Edition (ICD-10) Acknowledgement Testing and End-to-End Testing" MLN Matters® Article - Released
- "Ambulance Fee Schedule" Fact Sheet - Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet - Revised
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course - Revised

MLN Connects® Provider eNews for January 22, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-01-22-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-01-22-eNews.pdf

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI - Upcoming 2015 Calls

CMS Events

- eHealth Webinar: QRDA I Submission for Eligible Hospitals

Announcements

- Bidding Open for the Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program
- Cervical Health Awareness Month
- Major Improvements to the Internet-based PECOS System
- Submission Timeframes for 2014 PQRS Data
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- Updated Information on Reporting Menu Objectives for the EHR Incentive Programs
- January ICD-10 End-to-End Testing Participants Are Pre-Registered For April Testing
- Share Your ICD-10 Story

Claims, Pricers, and Codes

- January 2015 PPS Provider Data Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 Inpatient PPS 2015.3 Mainframe Pricer Update Available
- January 2015 Outpatient Prospective Payment System Pricer File Update
- Part A Claims Hold for Select Preventive and Screening Services - Updated

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 2]" Educational Tool - Released
- "2015 Medicare Part C and Part D Reporting Requirements and Data Validation" Web-Based Training Course - Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" MLN Matters® Article - Revised

- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for January 29, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-01-29-Enews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-01-29-Message.pdf

MLN Connects® National Provider Calls

- Payment of Chronic Care Management Services Under CY 2015 Medicare PFS - Registration Now Open
- ICD-10 Implementation and Medicare Testing - Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy
- Special Open Door Forum: Understanding Dialysis Facility Compare-Driving Informed Decision Making
- Special Open Door Forum: Adding Star Ratings to the Home Health Compare Website

Announcements

- Influenza Updates from CDC
- Pneumococcal Vaccinations Update from CMS
- CMS Launches Dialysis Facility Compare Star Ratings
- HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value
- EHR Incentive Program: Eligible Professional 2014 Attestation Deadline on February 28
- EHR Incentive Programs: New Stage 2 Summary of Care FAQ Provides Guidance on Measure #3
- Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- ICD-10 Resources

Claims, Pricers, and Codes

- Payment for HCPCS Code Q0091 as an RHC or FQHC Billable Visit under the All-Inclusive Rate System

Medicare Learning Network® Educational Products

- "Continued Use of Modifier 59 after January 1, 2015" MLN Matters® Article - Released
- "Telehealth Services" Fact Sheet - Revised
- "Medicare Part B Immunization Billing" Educational Tool - Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects® Provider eNews for February 05, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-02-05-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-02-05-eNews.pdf

MLN Connects® National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS - Register Now
- ICD-10 Implementation and Medicare Testing - Register Now
- New MLN Connects® National Provider Call Audio Recordings and Transcripts

MLN Connects® Videos

- Monthly Spotlight: Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing

CMS Events

- Special Open Door Forum: Home Health Clinical Templates

Announcements

- HHS Proposes Path to Improve Health Technology and Transform Care
- Extension of Temporary Moratoria on Enrollment of New HHAs, HHA Sub-units and Part B Ambulance Suppliers
- CLIA Individualized Quality Control Plan: Education and Transition Period Ends December 31, 2015
- 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs
- Open Payments: Second Year of Data Submission Begins
- CMS Intends to Engage in Rulemaking for EHR Incentive Program Changes for 2015
- Get Started with Hospice CAHPS
- Proposed Decision Memo: Screening for the HIV Infection

Claims, Pricers, and Codes

- Home Health Pricer will be Updated on April 1
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments" MLN Matters® Article - Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article - Revised
- "Internet-based PECOS Contact Information" Fact Sheet - Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format
- Subscribe to the MLN Matters® Electronic Mailing List
- Helpful Tips on Medicare Learning Network® Products and Learning Management System - Subscribe Now

MLN Connects® Provider eNews for February 12, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-02-12-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-02-12-eNews-file.pdf

MLN Connects® National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS - Last Chance to Register
- ICD-10 Implementation and Medicare Testing - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI - Registration Now Open

CMS Events

- Physician Compare Benchmark Discussion Webinars

Announcements

- DMEPOS Competitive Bidding: Register by Tuesday in Order to Bid
- February is American Heart Month
- IRF Quality Reporting Program: Data Submission Deadline February 15
- LTCH Quality Reporting Program: Data Submission Deadline February 15
- EHR Incentive Program: 2014 Attestation Deadline for Eligible Professionals February 28
- EHR Incentive Programs: Public Health Objectives: Reporting Requirements in Stage 1 and 2
- NCD for Screening for Lung Cancer with Low Dose Computed Tomography
- Background Fingerprints: Check Your Status Online
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- CY 2015 HH PPS PC Pricer and PPS Main Frame Pricer Updates Available

Medicare Learning Network® Educational Products

- "Hospital Outpatient Prospective Payment System" Fact Sheet - Revised
- "DMEPOS Quality Standards" Booklet - Reminder
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet - Reminder
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet - Reminder

MLN Connects® Provider eNews for February 19, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-02-19-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-02-19-eNews.pdf

MLN Connects® National Provider Calls

- ICD-10 Implementation and Medicare Testing - Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI - Register Now
- Video Slideshow and Follow-up Information Available for IRF-PAI MLN Connects® National Provider Call

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015
- Webinar for Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- Healthy Aging Summit

Announcements

- New *Affordable Care Act* Initiative to Encourage Better Oncology Care
- Update for Pharmacists Prescribing Part D Drugs
- Measles: Information for Healthcare Professionals
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- PQRS: Program Year 2014 QRDA III Submission Errors with Incorrect Program Name

Medicare Learning Network® Educational Products

- "Independent Diagnostic Testing Facility (IDTF)" Fact Sheet - Released
- "Chronic Care Management Services" Fact Sheet - Released
- "Provider Compliance Tips for Spinal Orthoses" Fact Sheet - Released
- "Provider Compliance Tips for Enteral Nutrition Pumps" Fact Sheet - Released
- "Provider Compliance Tips for Diabetic Test Strips" Fact Sheet - Released
- "Medicare Learning Network® Suite of Products & Resources for Educators and Students" Educational Tool - Reminder
- "Medicare Learning Network® Suite of Products & Resources for Billers and Coders" Educational Tool - Reminder
- "Medicare Learning Network® Suite of Products & Resources for Inpatient Hospitals" Educational Tool - Reminder
- "Medicare Learning Network® Suite of Products & Resources for Compliance Officers" Educational Tool - Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects® Provider eNews for February 26, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-02-26-eNews.html

View this edition as a PDF
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-02-26-eNews-.pdf

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI - Register Now
- Physician Quality Reporting Programs: Reporting Once in 2015 - Registration Now Open

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015

Announcements

- It's Still Flu Season
- CMS Strengthens Five Star Quality Rating System for Nursing Homes
- EHR Incentive Program: Deadline to Register Intent for a Public Health Measure is March 1
- Hospital Engagement Network Solicitation: Responses due March 30
- Medicare Geographic Reclassification under the IPPS Wage Index for FY 2016
- New FAQs on CY 2015 DMEPOS Medicare Payment Final Rule
- CMS to Release Comparative Billing Report in March on Modifier 25: Nurse Practitioners
- Sterilization of Ophthalmologic Surgical Instruments
- Two New ICD-10 Videos

Medicare Learning Network® Educational Products

- "Medicare Basics Commonly Used Acronyms" Educational Tool - Released
- "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492" MLN Matters® Article - Revised
- "The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - A Better Way for Medicare to Pay for Medical Equipment" Fact Sheet - Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects® Provider eNews for March 05, 2015

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-03-05-eNews.html

View this edition as a PDF

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-03-05-enews.pdf

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI - Last Chance to Register
- Physician Quality Reporting Programs: Reporting Once in 2015 - Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript
- Providers and Suppliers - Browse the MLN Connects® Call Program Collection of Resources

CMS Events

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

Announcements

- Help Your Medicare Patients "Bite into a Healthy Lifestyle" During National Nutrition Month® and Beyond
- Physician Groups that Demonstrate High Quality Care Receive Increases to Their Medicare Payments
- CMS Announces Release of 2015 Impact Assessment of Quality Measures Report
- Register for the Health Care Payment Learning and Action Network
- New EHR Attestation Deadline for Medicare Eligible Professionals: March 20
- Submission Extension for EPs Participating in PQRS via EHR and QCDR: March 20
- Hospital VBP FY 2017 Baseline Measures Report Now Available
- HHAs: Get Started with HHCAHPS Participation
- Request for Comments on ESRD Conditions for Coverage
- Physicians and Teaching Hospitals: Register in Open Payments System

- PQRS Payment Adjustments and Providers Who Rendered Services at IDTFs
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Special CBSA Codes for Home Health Claims
- FQHC Prospective Payment System File Update

Medicare Learning Network® Educational Products

- "Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program - Overview & Implementation" MLN Matters® Article - Released
- "Diagnosis Coding: Using the ICD-10-CM" Web-Based Training Course - Released
- "Medicare Physician Fee Schedule" Fact Sheet - Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet - Reminder
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet - Reminder
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Product Available In Electronic Publication Format

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!

DME MAC Jurisdiction A Local Coverage Determinations

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

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

Completion of Certificates of Medical Necessity (GEN)

Dear Physician:

Certificates of medical necessity, commonly known as CMNs, are documents used by the DME MACs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both, the medical need for, and the utilization of all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are your partners in caring for your patient. They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the *Social Security Act*, the law governing Medicare. Section 1842(p) (4) of the Act provides that:

> [i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Additionally, please remember that the information in the beneficiary's medical records must corroborate all information on the CMN. Help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Correct billing of Non-Invasive Interfaces Used in Conjunction with HCPCS Code E0472 - Joint DME MAC Publication (SPE)

Recently during claims review it was noted that suppliers are billing HCPCS code E0472 (RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)) with non-invasive interfaces. This is not correct billing. As noted in the code descriptor, code E0472 is reserved for devices used with an invasive interface. Claims for E0472 must not be billed with any of the following non-invasive interfaces or accessories:

A7027	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH
A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR
A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7031	FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH
A7032	CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH

A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR
A7034	NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP
A7035	HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7036	CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE
A7044	ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

Claims for devices used with a non-invasive interface are billed with HCPCS codes E0470 or E0471, depending on whether or not the device has a backup rate feature.

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

Correct Coding - Cast Covers - Joint DME MAC Publication (GEN)

Recently the DME MACs have received inquiries about coverage of covers for casts. These are typically constructed of latex or rubber and are designed to fit over a cast to allow bathing, showering or swimming without water infiltration. Medicare considers cast covers a convenience item; therefore, these items are non-covered. The proper HCPCS code for cast covers is:

A9270 - Non-covered item or service

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

Correct Coding - Fitness Monitoring Technologies - Joint DME MAC Publication (GEN)

Recently the DME MACs have received inquiries about coverage of fitness and rehabilitation tracking (FRT) technologies such as the FitBit®, WeGo®, Fuelband® and other devices such as pedometers, heart rate monitors, and GPS watches. FRTs are typically worn on the wrist and monitor the amount of exercise and movement of the wearer. FRTs are considered exercise equipment and are non-covered by Medicare. Suppliers billing FRTs must use HCPCS code A9300 (Exercise Equipment).

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 email the PDAC by completing the **DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html)**.

Correct Coding - Integrated Respiratory Products - Joint DME MAC Publication (SPE)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have recently had multiple inquiries about the coding of products where multiple functions, each with a separate HCPCS code, are incorporated into a single product. For example, there are positive airway pressure (PAP) and respiratory assist devices (RAD) that include integrated humidification. The correct codes for the integrated product are code E0601 (Continuous positive airway pressure (CPAP) device) for the base CPAP device and code E0562 (Humidifier, heated, used with positive airway pressure device) for the integrated humidification. The same principle applies to

respiratory assist devices with integrated humidification. The correct codes for the integrated RAD products are 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), or 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) for the base RAD device and code E0562 for the integrated humidification.

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 email the PDAC by completing the **DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html)**.

Correct Coding - Lithium Batteries - Updated (PDAC Article) (GEN)

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

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

A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
A4601	Lithium ion battery for non-prosthetic use, replacement
A4602	Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each
E2397	Power wheelchair accessory, lithium-based battery, each
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
L7367	Lithium ion battery, rechargeable, replacement

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

Codes A4602, K0604, and K0605 describe lithium batteries commonly used in external infusion pumps. Note that each code has an associated voltage. Claims for lithium batteries for external insulin infusion pumps (E0784) that do not use a voltage described by either code A4602, K0604, and K0605 must be billed using code A9999.

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

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

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

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

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

Correct Coding - Surgical Dressings Containing Non-Covered Components - DME MAC Joint Publication (SPE)

Some surgical dressings are produced containing non-covered components. This article reviews the coding guidelines for these items. The Surgical Dressings Local Coverage Determination (LCD) related Policy Article (PA) states:

> "Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multi-component products may not be unbundled and billed as the separate components of the dressing." (PA Coding Guidelines)

Historically, non-covered components have not been the majority constituent in multicomponent products. Recently, dressings where the non-covered components comprise the majority of the dressing have been identified.

The coding guideline for multi-component dressings states that the clinically predominant component will determine classification. Following this guideline:

- Dressings only containing non-covered components, with or without a substrate, are coded as A9270 (Non-covered item or service)
- Multicomponent dressings are coded based upon the clinically predominant component. For dressings that contain non-covered elements:
    - If the non-covered components are less than 50% of the dressing, coding is determined by the predominant covered component.
    - If the non-covered components comprise 50% or more of the dressing, the dressing is assigned to code A9270 (non-covered item or service).

Refer to the Surgical Dressing LCD and related PA for additional information about coding and coverage.

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

Correct Coding and Coverage - Peristeen® Transanal Irrigation System - Joint DME MAC Publication (SPE)

The Peristeen® transanal irrigation system is a device used to empty the lower bowel and to prevent chronic constipation and fecal incontinence or simply as a method of bowel management. The system consists of an enema bag, a rectal catheter with an inflatable balloon and a pump. Effective for claims with dates of service on or after January 1, 2015 the correct code to bill is:

A4459 MANUAL PUMP ENEMA SYSTEM, INCLUDES BALLOON, CATHETER AND ALL ACCESSORIES, REUSABLE, ANY TYPE

There is no Medicare benefit for this device; therefore, claims for code A4459 will be denied as noncovered (no Medicare benefit).

Code A4459 is an all-inclusive code at initial issue. Separate billing of any of the individual components is not allowed. The code is established as a single code to include all parts including the disposable supplies at initial issue. For refills of disposable supplies such as rectal catheters, HCPCS code A9270 (Noncovered item or service) should be used.

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 (https://www.dmepdac.com/contact/index.html)** located on the PDAC website.

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

Effective Date of 10-10-2014 - 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 5HT3 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 5HT3 antagonist, in combination with dexamethasone, is covered if, in addition to meeting the statutory coverage criteria specified in the related Policy Article, they are administered to beneficiaries who are receiving one or more of the anti-cancer chemotherapeutic agents listed in the LCD regarding oral anti-emetic coverage.

Claims for Akynzeo® must be billed using NOC code Q0181, and must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage and there must be no unbundling of the netupitant and palonosetron combination in Akynzeo®.

If Akynzeo® (Q0181) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of the LCD regarding oral antiemetics, a KX modifier must be added to each code. Further instructions in that policy include but are not limited to the following items.

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 (V58.11).

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

If Akynzeo® (Q0181) 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 for further information.

Coverage and Correct Coding of Blincyto™ - Joint DME MAC Publication (DRU)

On December 03, 2014, the FDA gave accelerated approval for Blinatumomab (Blincyto™) for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. Blincyto™ is a bispecific CD19-directed CD3 T-cell engager that activates endogenous T cells when bound to the CD19-expressing target cell (B cells). Activation of the immune system results in release of inflammatory cytokines. The FDA-approved schedule is for 6-week cycles, for a total 5 cycles.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Blincyto™ and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD).

Blincyto™ can be administered in multiple inpatient and outpatient settings. However, the DME MACs will only process claims for blinatumomab when it is administered to a Medicare beneficiary every 48 hours in an unsupervised home setting, with drug cassette exchanges that do not require supervision performed at a hospital/outpatient infusion facility. Claims to the DME MACs for Blincyto™ administered in any other setting will be rejected as wrong jurisdiction.

Claims for Blincyto™ for dates of service on or after December 03, 2014, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

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.

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

Coverage and Correct Coding of Continuous Glucose Monitoring (CGM) Devices - Revised December 2014 - Joint DME MAC Publication (SPE)

Note: *This article was originally posted July 2014. It is revised to allow for separate billing of supplies used with CGMs.*

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

Coverage

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

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

Coding

CGM systems are provided either as complete stand-alone systems or with one or more components integrated into an external insulin infusion pump. For stand-alone systems and related supplies, use the following HCPCS codes:

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

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

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

The following HCPCS codes are used for insulin pumps and related supplies:

E0784 EXTERNAL AMBULATORY INFUSION PUMP, INSULIN

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

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

Billing

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received multiple inquiries regarding correct coding for integrated products with multiple functions, each with a separate HCPCS code.

For CGM capability that is integrated into an insulin pump, the receiver/monitor (A9278) is considered as included in the coding for the infusion pump. There is no separate or additional coding for the integrated CGM receiver/monitor. Claims for separate billing will be denied as unbundling.

For CGM capability integrated into an external insulin infusion pump, the transmitter and supplies for CGM use are separately billable. Supplies are billed using code A9276. Code A9277 should be used for the non-integrated transmitter. Claims for CGM supplies and non-integrated system components will be denied as statutorily non-covered, no benefit.

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

For questions about correct coding, contact the 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 email the PDAC by completing the **DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html)**.

Coverage and Correct Coding of Duopa® (Levodopa-Carbidopa Enteral Suspension) - Joint DME MAC Publication (DRU)

On January 09, 2015, Duopa® (AbbVie) was approved by the FDA. Duopa® is an enteral-suspension combination of levodopa and carbidopa, and is indicated for the treatment of Parkinson's disease (PD). Duopa® is administered as a continuous 16-hour infusion into the jejunum through a percutaneous endoscopic gastrostomy-jejunal tube (PEG-J), using a CADD®-Legacy 1400 portable infusion pump.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Duopa® and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD). Refer to the External Infusion Pump LCD and Policy Article for specific coverage requirements.

Claims for Duopa® for dates of service on or after January 09, 2015 must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

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.

Establishment of the transabdominal port with a PEG-J is performed under endoscopic guidance by a gastroenterologist or other healthcare provider experienced in this procedure. The PEG-J is considered a supply provided incident to a physician's service, and

claims for this item are processed by the A/B MAC contractor. Claims to the DME MAC for the PEG-J will be rejected as wrong jurisdiction.

Refer to the, 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 (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 (https://www.dmepdac.com/contact/index.html)**.

Coverage and Correct Coding of HyQvia® Joint DME MAC Publication (DRU)

On September 12, 2014, HyQvia® (Baxter) was approved by the FDA for the treatment of primary immunodeficiency (PI) in adults. HyQvia® is a recombinant human hyaluronidase-facilitated subcutaneous infusion of human immunoglobulins. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated HyQvia® and determined that it is not eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD).

Claims for HyQvia® will be denied as discussed in a joint DME MAC bulletin article that was posted on June 24, 2011, titled "*Drugs Used With External Infusion Pumps - Coverage and Billing Reminders*." That article described various infusion drug and pump billing scenarios and stated, in pertinent part:

1. Billing for an infusion drug alone (no pump being used). There is no statutory infusion drug benefit to allow coverage. All infusion drugs and any associated supplies will be denied as statutorily non-covered.
2. Billing for a pump with an infusion drug not listed in the LCD. The External Infusion Pump is periodically updated to list specific drugs eligible for coverage. Drugs not listed in the LCD, including the associated pump and supplies, will be denied as not reasonable and necessary. HyQvia® will not be added to the LCD as a covered drug.

Please refer to the entire bulletin article referenced above, the External Infusion Pump LCD and related Policy Article for additional information.

Claims for HyQvia® for dates of service on or after September 12, 2014 must be submitted using the DME miscellaneous code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

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.

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 email the PDAC by completing the **DME PDAC Contact Form (https://www.dmepdac.com/contact/index.html)**.

Coverage Reminder - Osteogenesis Stimulators - Joint DME MAC Publication (SPE)

A recent examination of CERT reviews for osteogenesis stimulator claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

Reasons for Denial

- Prescriptions
  - Physician's detailed written order is missing, incomplete, or invalid - 25%
- Reasonable & Necessary (R&N)
  - National Coverage Determination (NCD) for osteogenesis stimulators (150.2) coverage criteria for radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with E0747 not met - 53%
- Other
  - Face-to-Face requirement not met - 6%
  - Missing CMN - 3%
  - Unsigned Clinical Notes or use of Signature Stamps - 9%

Payment Rules

Prescriptions

All items billed to Medicare require a prescription. A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. **Signature and date stamps are not allowed.** Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes E0747, E0748, and E0760 as specified in the table contained in the Policy Specific Documentation Requirements Section of the Local Coverage Determination (LCD) for Osteogenesis Stimulators. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO **before** dispensing the item.

Face-to-Face Documentation

ACA 6407 requires face-to-face documentation that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered for the HCPCS codes E0747, E0748, and E0760 as specified in the table contained in the Policy Specific Documentation Requirements Section of the LCD for Osteogenesis Stimulators.

Reasonable and Necessary (R&N) Criteria

The NCD and LCD for Osteogenesis Stimulators both mandate that coverage for a non-spinal electrical osteogenesis stimulator (E0747) is covered for nonunion of a long bone fracture defined as **radiographic evidence** that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator (criteria 1). Nonunion of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a **written interpretation** by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

Documentation

In the event of a claim review:

- Medicare requires a WOPD.
- Medicare requires Face-to-Face documentation.
- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements were met.

This article presents a summary of the policy requirements related to the errors identified in a CERT review. There are additional requirements necessary for coverage that are not discussed in this article. Please refer to the Osteogenesis Stimulator LCD and related Policy article for complete information.

Further education regarding this policy is available on your DME MAC contractor website.

DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps - Joint DME MAC Publication (PEN)

The DME MACs use DME Information Form (DIF) when processing claims to assure the most current information is on file and to allow the claims to pay correctly. Claims for enteral and parenteral nutrition and external infusion pumps require a DIF to be submitted with the initial claim as well as when changes in the items or quantities provided are made. DIFs are completed entirely by the supplier and do not need to be signed by the treating physician. DIFs are required to be signed and dated by the supplier.

The following table indicates the DIFs for external infusion pumps and enteral/parenteral nutrition.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutrition

The Initial DIF: A new Initial DIF is required when:

1. An enteral formula billed with a different code, which has not been previously certified, is ordered; or,
2. For either enteral formulas or administration via pump (B9000 or B9002), there has been a break in billing of more than 60 days (plus the remaining days in the rental month) and there has been a change in the underlying medical condition that justifies coverage for the item(s).
3. A beneficiary receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump* (B9000 or B9002).

*Change in method of administration from gravity or syringe to a pump (B9000 or B9002) requires a new initial DIF for the pump and a revised DIF for the enteral nutrient (See chart below).

The Revised DIF: Required when there has been a change in any of the information recorded on the DIF. The table below lists changes that require a Revised DIF to be submitted:

Reason	Category
Changes in the drug HCPCS code	External Infusion
Change in the route of administration	External Infusion
Change in method of administration	External Infusion
Change in HCPCS code for the current nutrient provided	Nutrition
Change (increase or decrease) in the calories prescribed	Nutrition
Change in the method of administration from gravity to syringe or syringe to gravity (See above for gravity or syringe to pump)	Nutrition
Change in the number of days per week of administration	Nutrition
Change in route of administration from tube feedings to oral feedings (if billing for denial)	Nutrition

The Recertification DIF: Must be submitted when the length of need previously entered on the DIF has expired and the ordering physician is extending the length of need for the item(s).

The DIFs for External Infusion Pumps and Enteral or Parenteral Nutrition can be located on each DME MAC web site.

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

HCPCS Code Update - 2015 (PDAC Article) (GEN)

The original version of this article can be found on the PDAC Web site at:
https://www.dmepdac.com/resources/advisory_articles.html

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2015.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2015.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2014, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2015.

There is no grace period that would allow submission of the discontinued code for dates of service in 2015.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2015.

The appearance of a code in this list does not necessarily indicate coverage.

Cervical Traction Devices

Narrative Changes

Code	Old Narrative	New Narrative
E0856	Cervical traction device, cervical collar with inflatable air bladder	Cervical traction device, with inflatable air bladder(s)

External Infusion Pumps

Added Code

Code	Narrative
A4602	Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each
J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg

Discontinued Code

Code	Narrative	Crosswalk to Code
J2271	Injection, morphine sulfate, 100mg	J2270
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	J2274

Immunosuppressive Drugs

Added Code

Code	Narrative
Q2052	Services, supplies and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration (Effective 4/1/2014)

Knee Orthoses

Added Code

Code	Narrative
K0901	Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Effective 10/1/2014)
K0902	Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Effective 10/1/2014)

Power Wheelchair

Narrative Changes

Code	Old Narrative	New Narrative
E0986	Manual wheelchair accessory, push activated power assist, each	Manual wheelchair accessory, push-rim activated power assist system

Miscellaneous

Added Code

Code	Narrative
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type
A4601	Lithium ion battery, rechargeable, for non-prosthetic use, replacement

Refractive Lenses

Narrative Changes

Code	Old Narrative	New Narrative
V2799	Vision service, miscellaneous	Vision item or service, miscellaneous

Upper Limb Orthotics

Added Code

Code	Narrative
L3981	Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments

Upper Limb Prosthetics

Added Code

Code	Narrative
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal
L7259	Electronic wrist rotator, any type

Discontinued Code

Code	Narrative	Crosswalk to Code
L6025	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device	L6026
L7260	Electronic wrist rotator, otto bock or equal	L7259
L7261	Electronic wrist rotator, any type	L7259

Narrative Changes

Code	Old Narrative	New Narrative
L7367	Lithium ion battery, replacement	Lithium ion battery, rechargeable, replacement

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

Items Provided on a Recurring Basis and Request for Refill Requirements - Reminder (GEN)

Requirements

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

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

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

Documentation Requirements

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

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

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

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

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

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

Billing Frequencies

For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

For additional information, refer to CMS' *Program Integrity Manual*, Internet-Only Manual, CMS Pub. 100-08, Chapter 5, Section 5.2.5 and 5.2.6, and the applicable Local Coverage Determinations and the *Supplier Manual*.

Modifier Requirements Due To Lack of a Physician's Order (Modifier EY) (GEN)

We have recently received inquiries regarding the proper submission of modifiers EY, GY, and GA when a denial is anticipated due to the lack of a prescription. To reduce errors related to this process, it is important to remember that all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items require a prescription (physician's order). Some DMEPOS items require a detailed written order prior to dispensing (WOPD), while others require a detailed written order (DWO) prior to billing. The specific requirements for an order are specified in the Medical Policy (Local Coverage Determination and/or Policy Article) for the specific item.

Please remember that if you submit a claim to Medicare and specified requirements for an order are not met, you must append modifier EY ("No physician or other licensed health care provider order for this item or service") to the claim line. This informs the Durable Medical Equipment, Medicare Administrative Contractor (DMEMAC) that you do not have a physician's order for the item. Additionally, items submitted with the EY modifier must be on a separate claim from those items not requiring an EY modifier.

When lack of an order is expected to result in a **medical necessity** denial (ANSI 50 - "These are non-covered services because this is not deemed a 'medical necessity' by the payer"), you must execute an Advance Beneficiary Notice of Noncoverage (ABN) if you intend to protect your company from financial liability. If you have properly executed an ABN, you must append modifier GA ("Waiver of liability statement issued as required by payer policy, individual case") to the claim line in addition to modifier EY.

However, when the lack of a physician's order is expected to result in a **statutory denial**, an ABN is not required. If you correctly submit the claim with modifier EY appended to the claim line, the claim will process and deny with ANSI 96 ("Non-covered charge(s)"). Neither modifier GY ("Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit") nor modifier GA is required when an item is expected to deny on the basis of a statutory denial (ANSI 96).

As a reminder, all items specified in Change Request 8304 which are subject to the *Affordable Care Act* 6407 require a WOPD. This is a statutory requirement. You must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. If you deliver the item prior to your receipt of a written order, it will be denied as statutorily noncovered. Therefore, when you do not have an order for these items, you must submit the claim with modifier EY. Again, neither modifier GY nor GA would be required.

We encourage you to refer to the LCD and related Policy Article for specific order and other documentation requirements for the items you provide.

Related links: **Change Request 8304 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R468PI.pdf)**

Proof of Delivery Reminder - Joint DME MAC Publication (GEN)

Recently during claims review it was noted that suppliers have a misunderstanding about the purpose of Proof of Delivery (POD). All items of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) require POD. Proof of delivery serves multiple purposes, the most obvious being confirmation that the beneficiary received the item for which Medicare was billed. In addition to confirming receipt of an item, POD also serves other functions in Medical Review, specifically the ability of contractor's review staff to determine correct coding. As noted in the Documentation Section of the DME MAC local coverage determinations (LCDs):

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

To enable review staff to make a correct coding determination, there must be sufficient details about the item delivered to ascertain whether or not the item(s) on the detailed written order are the same item(s) included on the claim and coded with the correct HCPCS code. To accomplish this task, the POD must contain specific information about the products to make this determination. As noted in the DME MAC LCD Documentation Section for each of the three methods of delivery, one of the requirements for proper POD documentation is:

Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)

Reviewers often see a reiteration of the HCPCS code narrative on the POD form as the detailed description of the item, particularly for orthotics and prosthetics. This is NOT adequate for POD purposes. Simply restating the HCPCS code narrative description does not allow review staff to determine what specific item(s) is being billed and if it is coded correctly. The preferred method is use of a brand name and model number, brand name and serial number or manufacturer name and part number to identify the product. If this type of information is not available for the product, suppliers may use a detailed narrative description of the item; however, it must contain sufficient descriptive information to allow a proper coding determination. This "narrative description" of the item is not the HCPCS code narrative.

Proof of delivery documents that fail to properly identify DMEPOS products and allow reviewers to make a correct coding determination will be denied for insufficient delivery information.

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

LCD and Policy Article Revisions Summary for February 20, 2015 (SPE)

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

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Coverage for Levodopa-Carbidopa enteral suspension (effective for dates of service on or after 01/09/2015)

Added: Coverage for Blinatumomab (effective for dates of service on or after 12/03/2014)

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

HCPCS CODES AND MODIFIERS:

Added: Codes A4602 and J2274

Deleted: Codes J2271 and J2275

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Group 4 Paragraph:

Added: HCPCS Code for Levodopa-Carbidopa enteral suspension

Group 4 Codes:

Added: ICD-9 Code 332.0

Group 5 Paragraph:

Added: HCPCS Code for Blinatumomab

Group 5 Codes:
Added: ICD-9 Code 204.02
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: 01/01/2015
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:
Added: Coding requirements for lithium batteries
Deleted: References to codes J2271 and J2275
Added: Levodopa-Carbidopa enteral suspension (effective for dates of service on or after 01/09/2015)
Added: Blinatumomab (effective for dates of service on or after 12/03/2014)

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

LCD and Policy Article Revisions Summary for February 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.

Lower Limb Prostheses

LCD
Revision Effective Date: 01/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Standard language regarding Medicare coverage
HCPCS CODING:
Revised: HCPCS Narrative of L7367
DOCUMENTATION REQUIREMENTS:
Added: Continued need, continued use, and Prior Payer verbiage and updated standard language documentation
Revised: Repair/Replacement verbiage

Power Mobility Devices

LCD
Revision Effective Date: 01/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
HCPCS CODES:
Revised: HCPCS Narrative for E0986
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 and repair/replacement verbiage

Policy Article
Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: HCPCS Narrative for E0986 and updated standard language documentation

Refractive Lenses

LCD

Revision Effective Date: 01/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language regarding Medicare coverage
HCPCS CODING:
Revised: HCPCS V2799 Narrative
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Continued need, continued use, and repair/replacement
Revised: Changed ICD-9 reference to diagnosis

Policy Article

Revision Effective Date: 05/01/2013 (February 2015 Publication)
Removed: Reference to ICD-9 located in the narrative

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 5, 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.

Cervical Traction Devices

LCD

Revision Effective Date: 01/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Standard language regarding Medicare coverage
HCPCS CODING:
Revised: HCPCS Narrative of E0856
DOCUMENTATION REQUIREMENTS:
Added: Items provided on a periodic basis requirements to DWO
Revised: Standard language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Revised: HCPCS E0856 Narrative in ACA table
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: HCPCS E0856 Narrative in ACA table
Removed: "When required by state law" from ACA new prescription requirements

Hospital Beds and 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
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

Intravenous Immune Globulin

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: Refill 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 Article

Revision Effective Date: 01/01/2011 (March 2015 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: ICD-9 codes from this section

Added: Reference to ICD-9 codes section

Mechanical In-exsufflation 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

Added: Repair/Replacement section

Revised: Removed ICD-9 reference from diagnosis code statement

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.*

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

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

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

Documentation Requested

The following documentation is requested to perform the DCR:

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

Current Review Results

These findings are for claims processed from April 01, 2014 through June 31, 2014:

- The review involved DCRs of 7,051 claims (including reopenings)
- Of the 7,051 claims reviewed, 2,970 claims were denied resulting in a claim denial rate of 42%.
- An additional 711 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

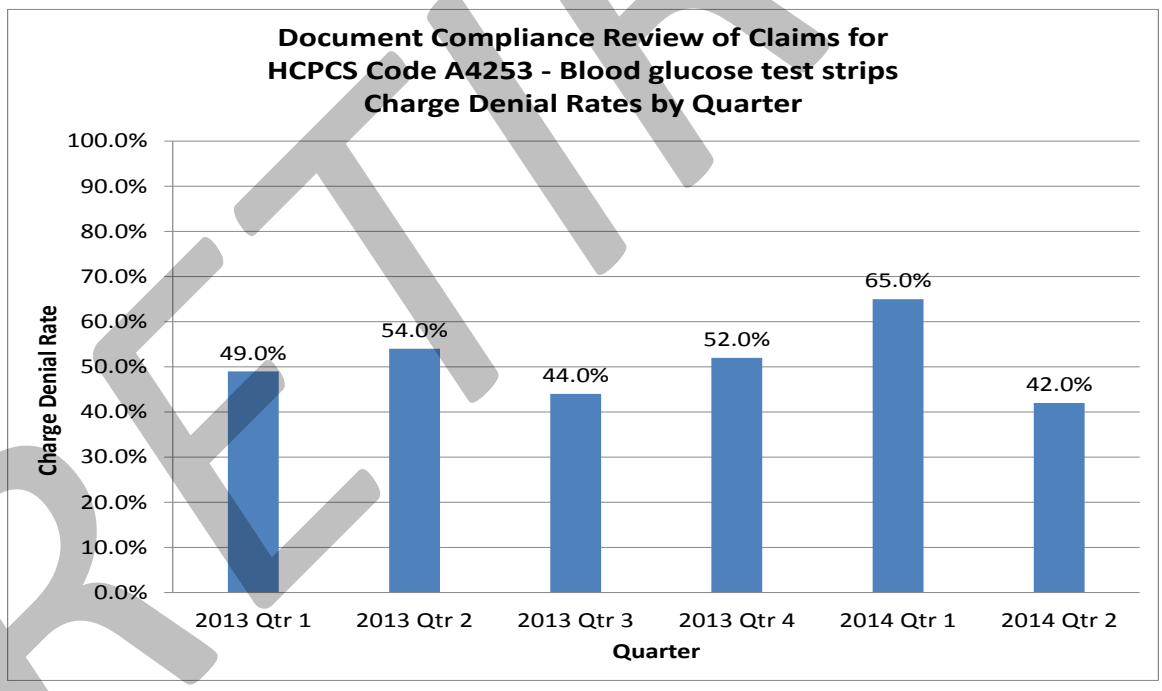
Primary Reasons for Denial

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

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

Denial Rate - Historical Results

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



Next Step

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for HCPCS A4253. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is

compliant with all requirements. Suppliers are encouraged to visit our web site at **http://www.medicarenhic.com** for all your educational needs and to review the following references:

- **Items Provided on a Recurring Basis and Request for Refill Requirements – Revised**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx
- **Coverage Reminder - Requirements for High Utilization of Glucose Monitor Strips and Lancets**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx
- **Glucose Monitor LCD (L11530) and Related Policy Article (A33614)**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **DME MAC A Glucose Monitor Tutorial**
  http://www.medicarenhic.com/dme/eduonline.aspx
- **DME MAC A Glucose Documentation Podcast**
  http://www.medicarenhic.com/dme/eduonline.aspx
- **Results of Documentation Compliance Review (DCR) of Claims for HCPCS A4253**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- **Documentation Reminder - Glucose Monitor Logs for High-Utilization Claims**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx
- **Glucose Monitors and Supplies - Dear Physician Letter**
  http://www.medicarenhic.com/dme/mobile/index.html

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

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

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

Documentation Requested

The following documentation is requested to perform the DCR:

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

Current Review Results

These findings are for claims processed from July 01, 2014 through September 31, 2014:

- The review involved DCRs of 5,019 claims (including reopenings)
- Of the 5,019 claims reviewed, 2,096 claims were denied resulting in a claim denial rate of 42%.
- An additional 823 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

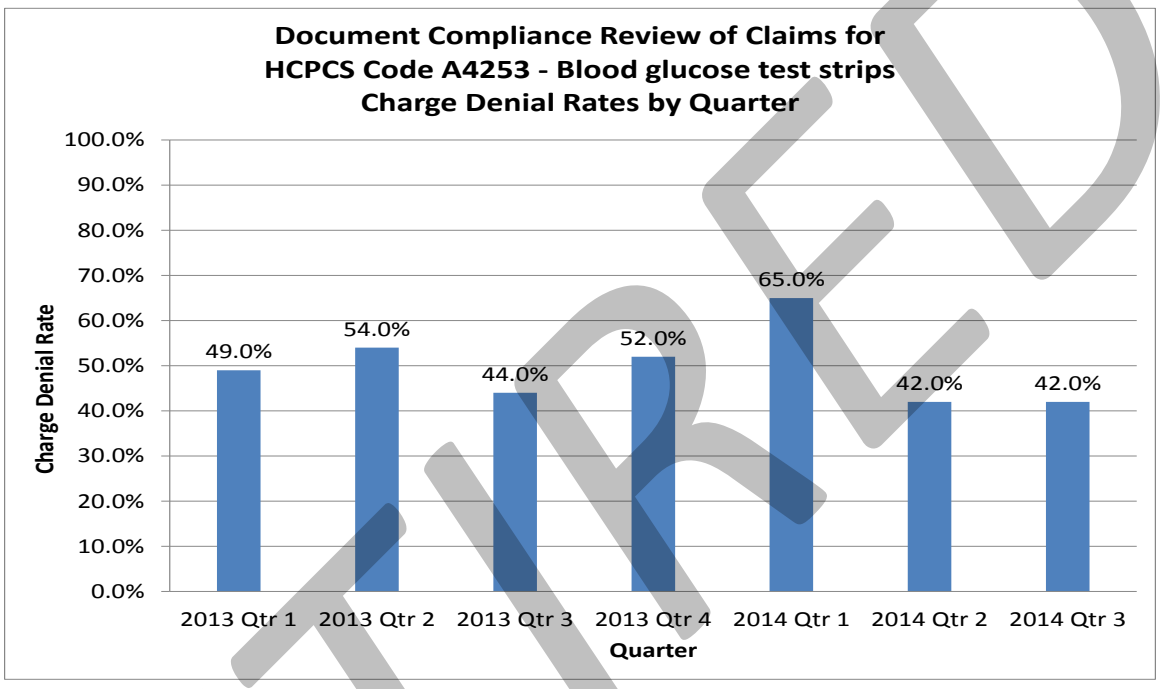
Primary Reasons for Denial

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

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

Denial Rate - Historical Results

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



Next Step

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

Educational References

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

- **Items Provided on a Recurring Basis and Request for Refill Requirements – Revised**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx
- **Coverage Reminder - Requirements for High Utilization of Glucose Monitor Strips and Lancets**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx
- **Glucose Monitor LCD (L11530) and Related Policy Article (A33614)**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **DME MAC A Glucose Monitor Tutorial**
  http://www.medicarenhic.com/dme/eduonline.aspx

- **DME MAC A Glucose Documentation Podcast**
  http://www.medicarenhic.com/dme/eduonline.aspx
- **Results of Documentation Compliance Review (DCR) of Claims for HCPCS A4253**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- **Documentation Reminder - Glucose Monitor Logs for High-Utilization Claims**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx
- **Glucose Monitors and Supplies - Dear Physician Letter**
  http://www.medicarenhic.com/dme/mobile/index.html

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

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

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

Documentation Requested

The following documentation is requested to perform the DCR:

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

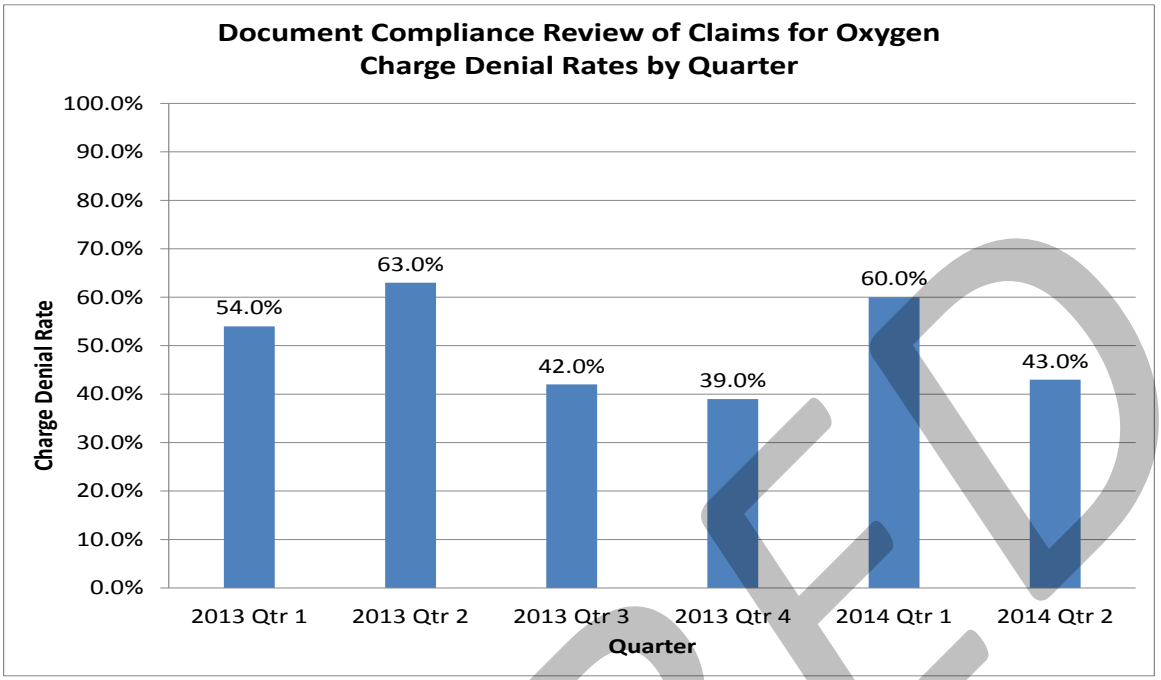
Current Review Results

These findings are for claims processed from April 01, 2014 through June 31, 2014:

- The review involved DCRs of 2,976 claims (including reopenings)
- Of the 2,976 claims reviewed, 1288 claims were denied resulting in a claim denial rate of 43%
- 220 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Denial Rate - Historical Results

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



Primary Reasons for Denial

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

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

Next Step

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

Educational References

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

- **The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **CERT Physician Letter - Oxygen & Supplies**
  http://www.medicarenhic.com/dme/mobile/index.html
- **Frequently Asked Questions** (search word oxygen)
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- **Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)** **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**
- **Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- **Payment Rules Reminder - Home Oxygen Initial Qualification Testing - Joint DME MAC Publication**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx

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

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

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

Documentation Requested

The following documentation is requested to perform the DCR:

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

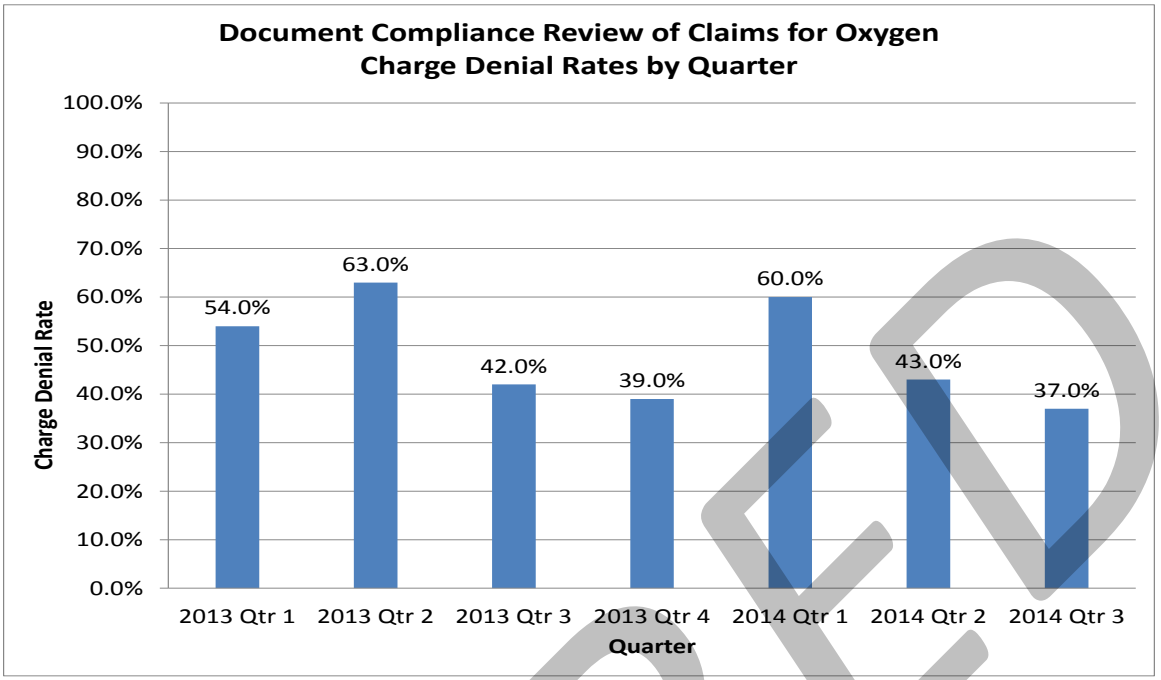
Current Review Results

These findings are for claims processed from July 01, 2014 through September 31, 2014:

- The review involved DCRs of 1,826 claims (including reopenings)
- Of the 1,826 claims reviewed, 681 claims were denied resulting in a claim denial rate of 37%
- 29 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Denial Rate - Historical Results

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



Primary Reasons for Denial

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

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

Next Step

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

Educational References

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

- **The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **CERT Physician Letter - Oxygen & Supplies**
  http://www.medicarenhic.com/dme/mobile/index.html
- **Frequently Asked Questions** (search word oxygen)
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- **Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)** **http://www.medicarenhic.com/dme/mrbulletinpca.aspx**
- **Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

- **Payment Rules Reminder - Home Oxygen Initial Qualification Testing - Joint DME MAC Publication**
  http://www.medicarenhic.com/dme/mrbulletincurrent.aspx

Results of Documentation Compliance Review (DCR) of Claims for Power Mobility Device, HCPCS K0823 (MOB)

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

DME MAC A Medical Review has been performing a service-specific Documentation Compliance Review (DCR) of HCPCS Code K0823 (Power Mobility Device) claims. This type of review is conducted when data analysis indicates there is a pattern of insufficient documentation in a product category. This review was initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

Documentation Requested

The following documentation is requested to perform the DCR:

- A copy of the Treating Physician's 7-Element Order for a Power Mobility Device.
- Copy of the Face-to-Face Evaluation.
- Copy of the home assessment.
- Copy of the detailed product description, listing all items/options and upgrades.
- Valid Proof of delivery

Current Review Results

These findings are for claims processed from April 01, 2014 through June 31, 2014:

- The review involved DCRs of 91 claims (including reopenings)
- Of the 91 claims reviewed, 14 claims were denied resulting in a claim denial rate of 15%
- 13 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Primary Reasons for Denial

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

- Face-to-Face missing signature from physician.
- Missing home assessment.
- Missing proof of delivery.

Next Step

Based on the results of this DCR, DME MAC A will continue to perform DCRs on HCPCS K0823. Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor.

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for HCPCS K0823. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to visit our web site at **http://www.medicarenhic.com** for all your educational needs and to review the following references:

- **The Power Mobility Device Local Coverage Determination (LCD) L21271**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

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

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

Results of Documentation Compliance Review (DCR) of Claims for Power Mobility Device, HCPCS K0823 (MOB)

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

DME MAC A Medical Review has been performing a service-specific Documentation Compliance Review (DCR) of HCPCS Code K0823 (Power Mobility Device) claims. This type of review is conducted when data analysis indicates there is a pattern of insufficient documentation in a product category. This review was initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

Documentation Requested

The following documentation is requested to perform the DCR:

- A copy of the Treating Physician's 7-Element Order for a Power Mobility Device.
- Copy of the Face-to-Face Evaluation.
- Copy of the home assessment.
- Copy of the detailed product description, listing all items/options and upgrades.
- Valid Proof of delivery

Current Review Results

These findings are for claims processed from July 01, 2014 through September 31, 2014:

- The review involved DCRs of 337 claims (including reopenings)
- Of the 337 claims reviewed, 43 claims were denied resulting in a claim denial rate of 13%
- 8 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Primary Reasons for Denial

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

- Delivery date does not match date of service.
- Missing physician signature on Face-to-Face
- Incomplete and missing home assessment.

Next Step

Based on the results of this DCR, DME MAC A will continue to perform DCRs on HCPCS K0823. Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor.

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for HCPCS K0823. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements. Suppliers are encouraged to visit our web site at **http://www.medicarenhic.com** for all your educational needs and to review the following references:

- **The Power Mobility Device Local Coverage Determination (LCD) L21271**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

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

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

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 36.9%. A summary of findings was published on the NHIC, Corp. Website on October 23, 2014. Based on this result, a widespread prepayment review was continued.

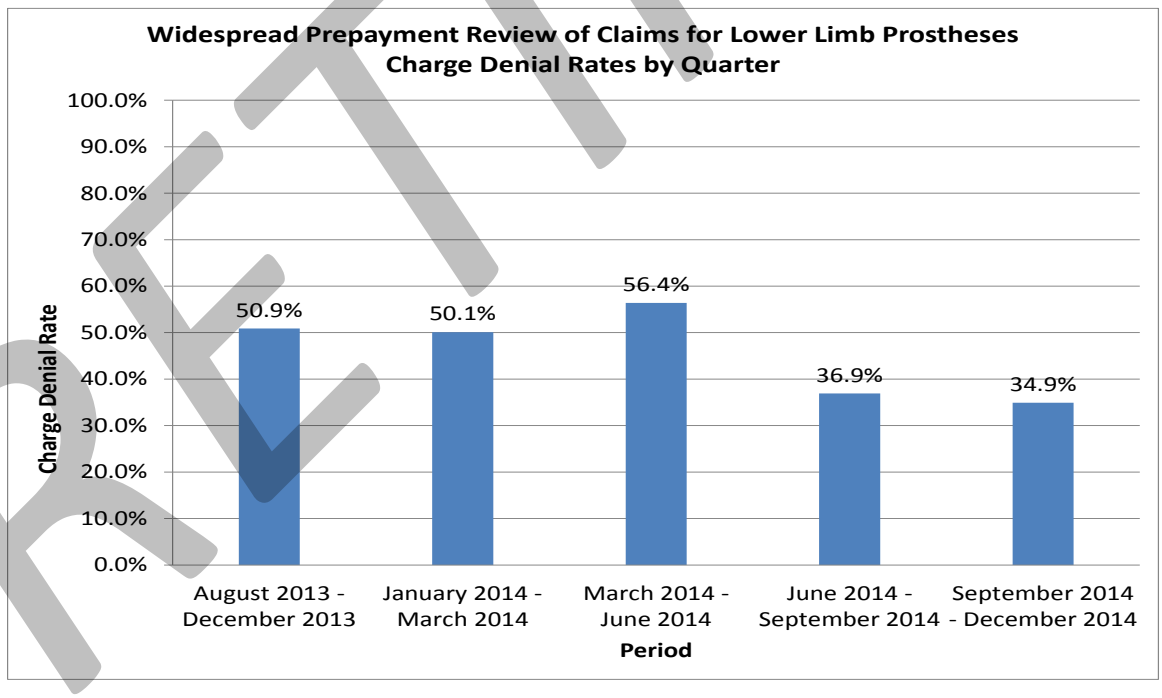
Current Review Results

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

The review involved prepayment complex medical review of 156 claims submitted by 111 suppliers for claims processed September 24, 2014 to December 16, 2014. Responses to the Additional Documentation Request (ADR) were not received for 17 (11%) of the claims. For the remaining 139 claims, 79 claims were allowed and 60 were denied resulting in a claim denial rate of 43%. The overall Charge Denial Rate was 34.9%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Lack of Medical Record Documentation

- 13% 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.

Proof of Delivery

- 2.7% of the denied claims were missing a valid Proof of Delivery. Proof of Delivery was missing items delivered; items must be documented with a narrative description or a manufacturer name and model number.

Claim Examples

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

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the evaluation/assessment documentation 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 2:

Received: The supplier submitted a Detailed Written Order, which includes the beneficiary's name, specific items dispensed, treating physician's signature and date, and the start date of order; Proof of Delivery that includes the manufacturer, model numbers and cost of each item, 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.

Example 3:

Received: The supplier submitted a Detailed Written Order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; 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.

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**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **Dear Physician Letter** - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/mobile/index.html
- **CERT Error Article**
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- **Results of Widespread Prepayment Complex Review for Lower Limb Prostheses**
  (Posted 01/21/2014; 04/24/2014; 07/24/2014; 10/23/2014)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- **Results of Widespread Prepayment Probe for Lower Limb Prostheses** (Posted 11/30/2011)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx

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

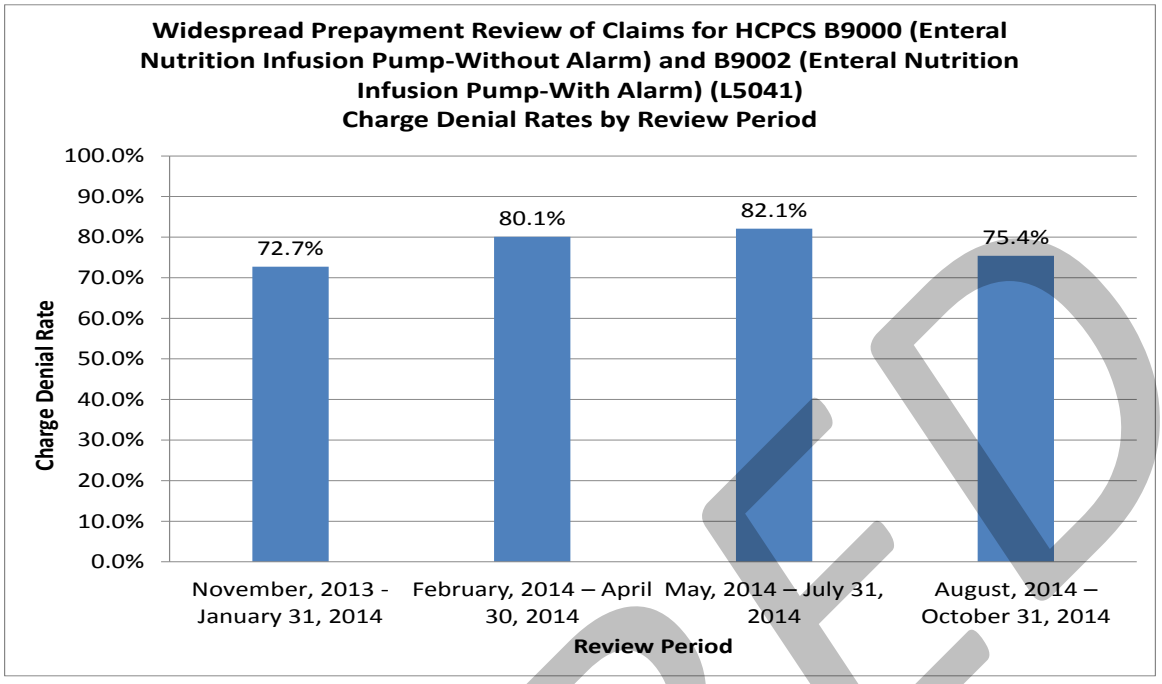
Historical Review Results

DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed May 1, 2014 through July 31, 2014 and resulted in 82.1% Charge Denial Rate (CDR).

Current Review Results

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

The review involved prepayment complex medical review of 821 claims submitted by 90 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 232 (28%) of the claims. For the remaining 589 claims, 132 claims were allowed and 457 were denied/partially denied resulting in a claim denial rate of 78%. 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 75.4%.



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

- 18% of the denied claims did not have any medical record documentation submitted.
- 25% 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.*
- 5% of the claims denied for statutory denial - did not meet prosthetic benefit requirement. Beneficiary able to tolerate oral nutrition.

Proof of Delivery

- 18% of the denied claims had no Proof of Delivery (POD).
- 22% 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

- 24% of the denied claims had missing detailed written orders.
- 16% of the denied claims had incomplete detailed written orders.
  - Date of the detailed order was incomplete (missing month or year)
  - Physician signature could not be authenticated

DME Information Form

- 8% missing DME Information Form
- 2% missing Enteral Pump HCPCS code

Claim Examples

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

Example 1:
Received: Delivery documentation with signature and date.
Missing: Detailed physician order, DIF, medical documentation

Example 2:
Received: Detailed physician order, medical documentation, delivery documentation with signature and date.
Missing: DIF

Example 3:
Received: Detailed physicians order with stamped signature, DIF, delivery documentation with signature and date
Missing: Medical documentation, detailed physician order with hand written signature and date.

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) http://www.medicarenhic.com/dme/mrbulletinpca.aspx**
  (Posted 09/25/2014; 06/26/2014; 03/27/2014; 12/27/2013; 09/13/2013; 06/28/2013; 03/08/2013; 07/20/2012; 05/11/2012; 12/22/2012; 09/20/2011; 03/11/2011)
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **CERT Physician Letter - Enteral Nutrition**
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- **Enteral Nutrition Units of Service Calculator**
  http://www.medicarenhic.com/dme/selfservice.aspx
- **Frequently Asked Questions** (search word Enteral)
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- **Enteral Nutrition Supply Kits - Coverage Reminder**
  http://www.medicarenhic.com/viewdoc.aspx?id=563
- **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 May 2014 through August 2014, and reported a CDR of 80.8%.

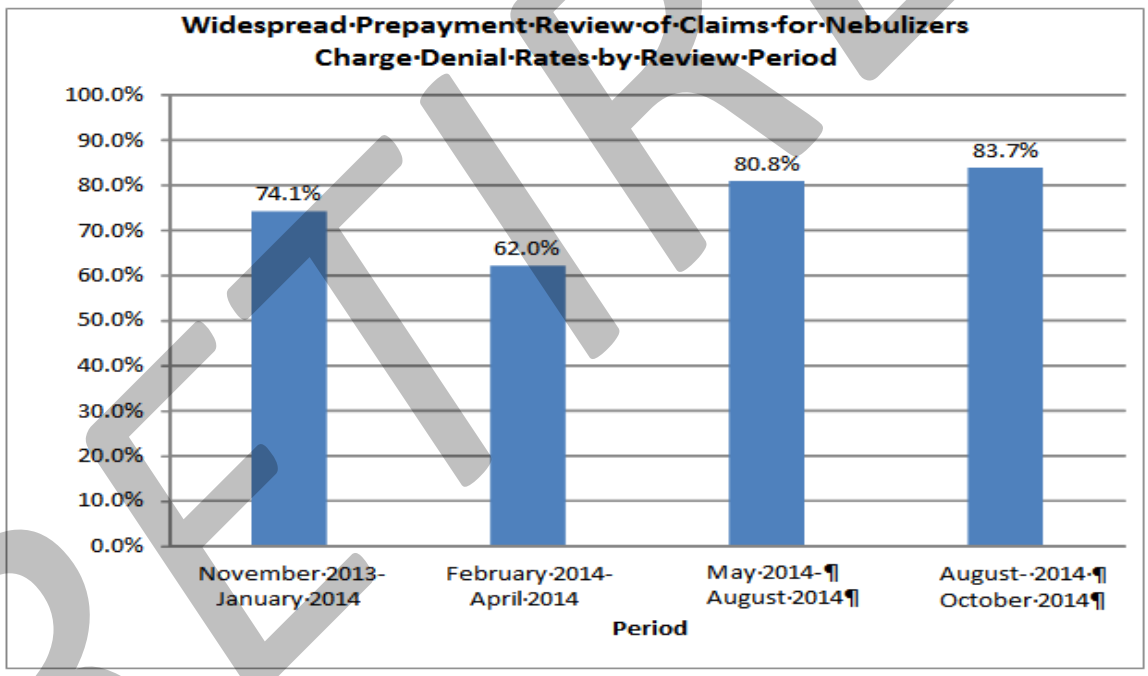
Current Review Results

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

The review involved prepayment complex medical review of 1,448 claims submitted by 422 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 429 (29%) of the claims. For the remaining 1,019 claims, 71 claims were allowed (7%) and 948 were denied/partially denied resulting in a claim denial rate of 93%. The overall CDR was 83.7%.

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

- 20% of the denied claims were missing clinical information to support reasonable and necessary.
  - No medical records were submitted
- 26% of the denied claims had insufficient or incomplete clinical documentation. The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer

        - Clinical documentation submitted did not mention a payable medical condition
        - Clinical documentation submitted had no mention of need for a nebulizer
    - Illegible copy of documentation submitted
    - Physician signature did not meet signature requirements including:
        - Missing physician's handwritten or electronic signature
        - Illegible physician signature with no printed name to verify against and no signature log submitted
        - Unsigned typed note with just physician's typed name

Written Order Prior to Delivery (WOPD)

- 3% of the denied claims were missing the written order prior to delivery.
- **82% of the denied claims had an incomplete or invalid written order prior to delivery.**
  The following are specific issues identified:
    - Missing the Physician's NPI number
    - Physician 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)
    - Incompatible combination of items ordered

Proof of Delivery Issues

- 5% 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(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).

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 to be dispensed, physician's signature, date of signature, physician's NPI number, clinical notes and proof of delivery
Missing: Incompatible combination of nebulizer supplies ordered 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.

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**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
  (Posted 09/13/2013; 12/12/2013; 03/20/2014; 06/26/2014)
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **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** (**http://www.medicarenhic.com/dme/rcseminars.aspx#liveline**) - The Monday chat sessions provide the opportunity to ask billing, policy, documentation and other general questions to the Outreach & Education Team

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 July 01, 2014 through September 30, 2014 and resulted in a CDR of 68.9%.

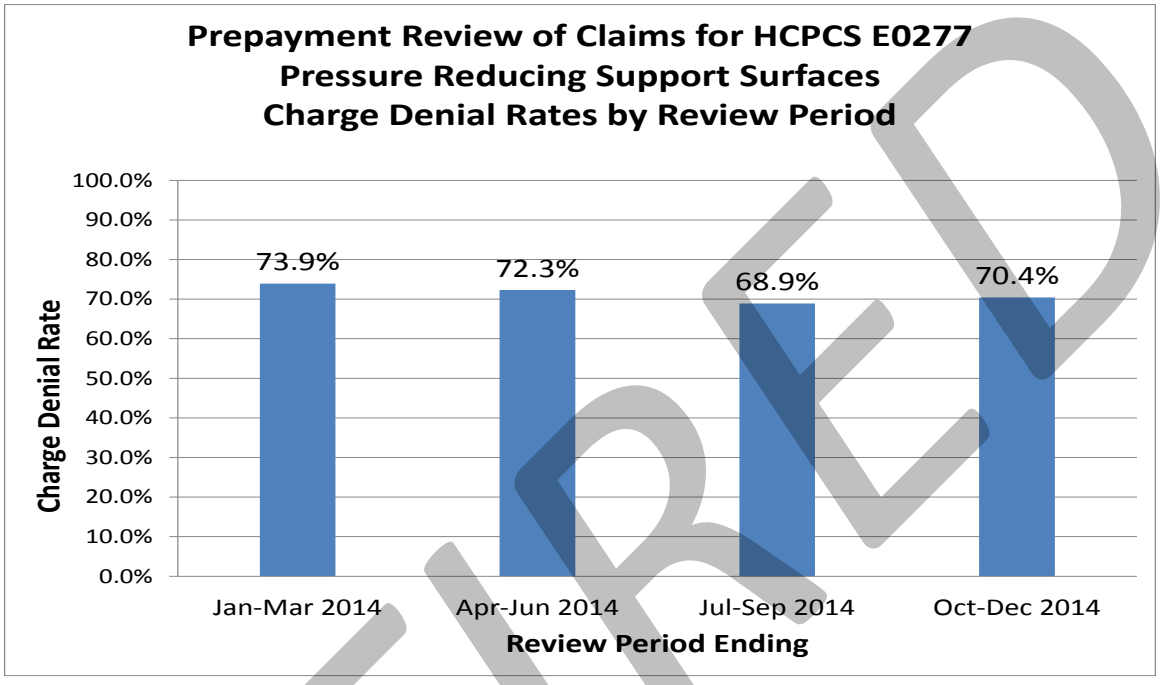
Current Review Results

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 October 01, 2014 through December 31, 2014.

The review involved prepayment complex medical review of 181 claims submitted by 57 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 77 (43%) of the claims. For the remaining 104 claims, 33 were allowed and 71 of the claims were denied. This resulted in a claim denial rate of 68%, and a CDR of 70.4%.

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

- 44% 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.
- 7% of the denied claims did not include medical documentation.

Written Order Prior to Delivery

- 9% of the denied claims contained a written order prior to delivery that was missing an order date/start date.
- 7% of the denied claims contained a written order prior to delivery that was dated after delivery.
- 4% of the denied claims were missing a written order prior to delivery.
- 3% of the denied claims contained a written order prior to delivery that did not include a narrative description or a brand name/model number of the item being dispensed.

Proof of Delivery Issues

- 6% of the denied claims were missing a proof of delivery.
- 4% of the denied claims contained proof of delivery that had a delivery date that was different than the date of service.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Group 2 Pressure Reducing Support Surface claims:

Example 1

Received:

- A written order prior to delivery which includes the beneficiary's name, detailed description of the item(s), physician's name, and physician signature and signature date;
- Medical records consisting of wound care notes 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.
- A written order prior to delivery that included a detailed description of the item being ordered.

Missing:

- A written order prior to delivery which includes the date of the order and the start date, if start date is different from the date of the order;
- Wound care notes and visiting nurse notes that contained 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.

Example 2

Received:

- A written order prior to delivery which includes the 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, and physician signature and signature date;
- Medical records consisting of nursing 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 a detailed description of the item(s).
- Nursing notes that contained 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:

- Medical records consisting of physician's notes;

Missing:

- A written order prior to delivery which includes the beneficiary's name, date of the order and the start date, if start date is different from the date of the order, physician's name, detailed description of the item(s), and physician signature and signature date;
- Physician's notes that contained 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 includes the beneficiary's name, delivery address, sufficiently detailed description to identify the item being delivered, quantity delivered, date delivered and beneficiary (or designee) signature that validates that the beneficiary received the items that were billed.

Next Steps

Based on the results of this prepayment review, DME MAC A will continue with a pre-pay 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**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces**
  http://www.medicarenhic.com/viewdoc.aspx?id=2311
- **Results of Widespread Prepayment Complex Medical Review for Group 2 Pressure Reducing Support Surfaces**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx (Posted 02/25/2014; 05/29/2014; 09/25/2014; 11/26/2014)

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 July 2014 through September 2014, and reported a CDR of 78.8%.

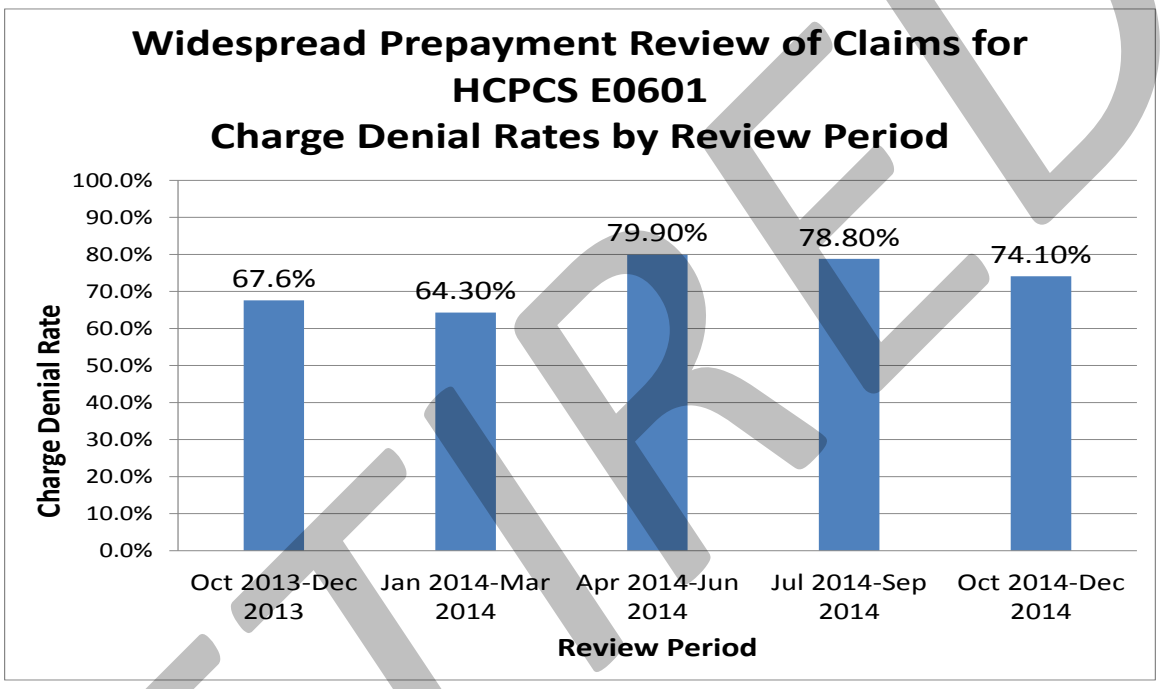
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from October 2014 through December 2014.

This review involved prepayment complex medical review of 2,022 claims submitted by 397 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 396 (20%) of the claims. Of the 1,626 claims for which responses were received, 347 claims were allowed and 1,279 were denied/partially denied. This resulted in a claim denial rate of 78.7%. The overall CDR was 74.1%.

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

- 11.7% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the 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
- 7.6% 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.
- 3% 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.
- 0.5% of the denied claims had illegible Face-to-Face documents.

Detailed Written Order/Written Order Prior to Delivery Issues

- 0.5% of the denied claims did not include the Detailed Written Order.
- 63% of the denied claims had an incomplete Written Order Prior to Delivery for PAP device E0601. (for claims with a Date of Service on or after January 01, 2014) Included in these for incomplete Written Order Prior to Delivery were orders which were missing either:
  - A.) Beneficiary's name
  - B.) The E0601 PAP device ordered
  - C.) The prescribing practitioner's National Provider Identification (NPI)
  - D.) The signature of the prescribing practitioner
  - E.) The date of the order
  - F.) Signature date on Detailed Written Order prior to Delivery
  - G.) A date of receipt demonstrating supplier receipt of Detailed Written Order on or before the Delivery
- 44.7 % 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

- 6% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 2.3% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.
- 2.7% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 6.9% of the denied claims did not include evidence of training on the PAP device.
- 8.2% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 3.7% of the denied claims were missing Proof of Delivery.
- 5.1% 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 Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: The Written Order Prior to Delivery is missing a date stamp or similar clearly showing supplier receipt of order prior to delivery of the E0601 PAP device. The Written Order Prior to Delivery is also missing the prescribing practitioner's National Provider Identification (NPI).

Example 2:

Received: Included in this claim for a beneficiary entering Medicare are a Face-to-Face clinical evaluation, a Detailed Written Order/Written Order Prior to Delivery, and Proof of Delivery.
Missing: The submitted documentation did not include documentation that the beneficiary had a diagnostic Sleep Test prior to FFS Medicare enrollment that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories.

Example 3:

Received: Included in this claim are a Detailed Written Order/Written Order Prior to Delivery, a Face-to-Face clinical evaluation by treat physician, a Medicare approved Sleep Study, Proof of Delivery, and evidence of Training on the PAP device.
Missing: The Detailed Written Order submitted includes a list of items that has created incompatible combinations and the ordering physician did not clearly identify the specific items that are being ordered for the beneficiary.

Next Step

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

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

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

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)**
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx (Posted 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)

- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **CERT Documentation Checklist**
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- **CERT Error Articles**
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- **Physician's Corner Check List**
  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 April 15, 2014 - August 28, 2014 and resulted in a CDR of 87.6%.

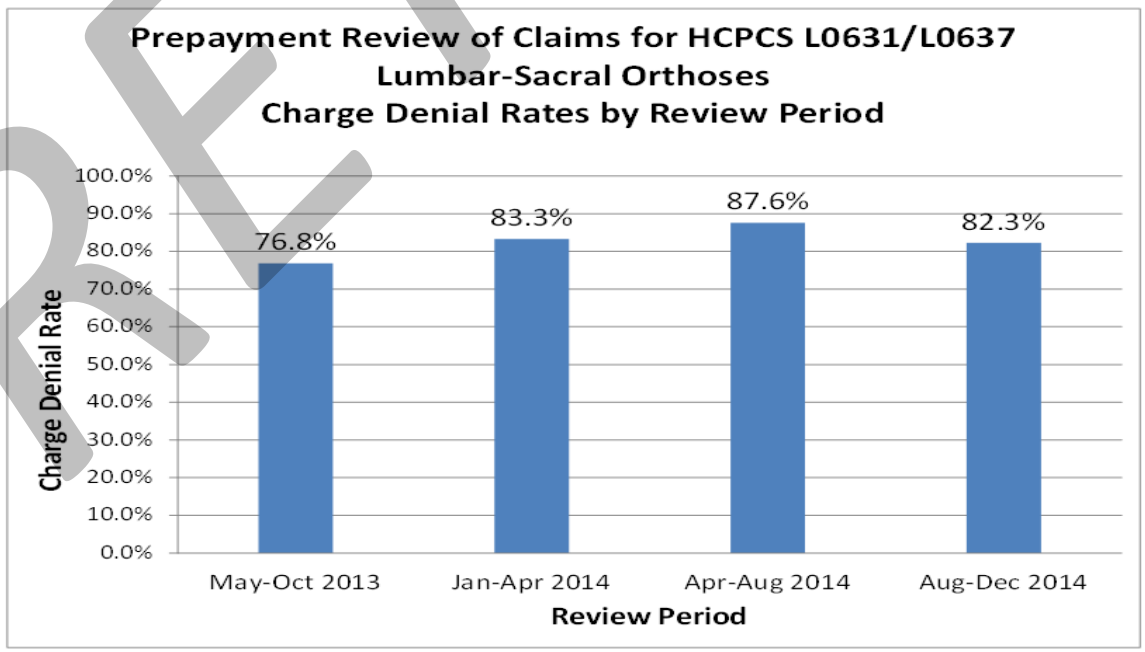
Current Review Results

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 from **August 29, 2014 - December 12, 2014**.

The review involved prepayment complex medical review of 1775 claims submitted by 338 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 486 (27%) of the claims. For the remaining 1,289 claims, 218 claims were allowed and 1071were denied resulting in a claim denial rate of 83%. The overall CDR was 82.3%.

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) (19%)
- Denied claims included an incomplete order (28%)
    - DWOs submitted were not legible and/or did not list beneficiary name (3%)
    - DWOs missing start date and/or signature date (10%)
    - DWOs do not specifically detail the item(s) (15%)

Medical Record Documentation Issues

- Denied claims missing the clinical documentation to support medical necessity (15%)
- Denied claims upon review of clinical documentation (30%)
    - Clinician notes submitted show a different beneficiary than stated within the claim submitted (1%).
    - 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 (23%).
    - 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) (17%)
- Proof of Delivery (POD) included delivery documentation was missing required elements (17%)
    - Delivery documentation 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) (4%)
    - Delivery documentation does not specifically describe item(s) delivered (4%)
    - Delivery documentation does not include delivery address. (7%)

Claim Examples

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

Example 1:

Received: The supplier submitted a DWO, which includes the beneficiary's name, treating clinician's signature, date of clinician's signature and start date of order; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the evaluation/assessment documentation for the item(s) billed. Proof of Delivery, with all the required elements was submitted.

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, date of appointment and clinician's signature.

Example 2:

Received: The supplier submitted clinical documentation to support medical necessity. Proof of delivery, with all but one 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. Delivery documentation submitted did not include a sufficiently detailed description to identify the item(s) being delivered. .

Example 3:

Received: The supplier submitted a valid DWO.

Missing: Clinical documentation submitted did not support medical necessity. 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.

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

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

Educational References

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

- **LCD for Spinal Orthoses: TLSO and LSO (L11470)**
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- **DME MAC Jurisdiction A Supplier Manual**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **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 July 01, 2014 through September 30, 2014 and resulted in a CDR of 67.7%.

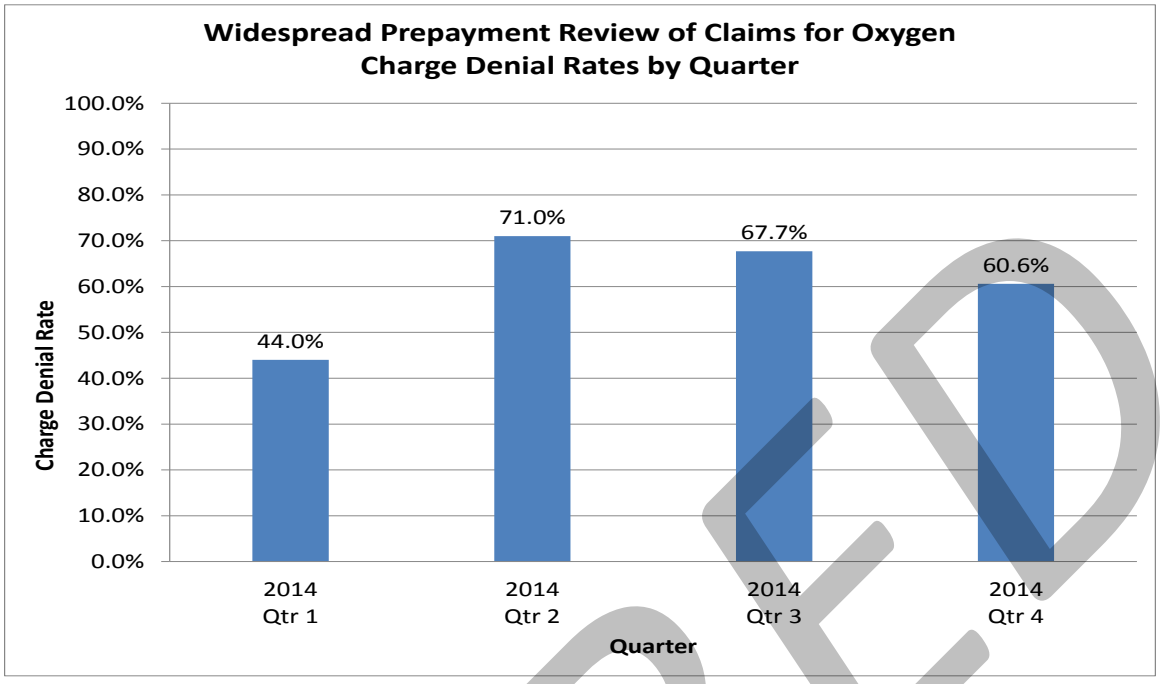
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from October 01, 2014 through December 31, 2014.

The review involved prepayment complex medical review of 627 claims submitted by 121 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 263 (42%) of the claims. For the remaining 364 claims, 103 claims were allowed and 261 were denied resulting in a claim denial rate of 72%, and a CDR of 60.6%.

Charge Denial Rate Historical Data

The following graph depicts 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
    a. The qualifying blood gas study was obtained under the following conditions:
    b. 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
4. 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 (41%)

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 (51%)
- Detailed written order was missing a description of the DME item(s) ordered (34%)
- Detailed written order was missing the prescribing practitioner's NPI (14%)
- Detailed written order was received after the date of delivery (12%)
- Detailed written order was signed after the date of delivery (10%)
- Detailed written order was missing the order date (5%)
- No detailed written order submitted (5%)
- Date of receipt by the supplier is illegible (3%)

- Detailed written order was missing the signature date (2%)

Missing Documentation (27%)

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

- 11% - Missing treating physician visit within 30 days prior to the initial certification date

Missing qualifying blood gas study per LCD L11468:

- 11% - No medical documentation to support the blood gas study reported on the CMN

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

- 3% - Missing an initial CMN or initial CMN was invalid

Missing valid proof of delivery per LCD L11468:

- 2% - Missing valid proof of delivery

Clinical Documentation Issues: Medical Necessity could not be established (32%)

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

- 10% - 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
- 7% - No indication in the medical documentation of the presence of a severe lung disease or hypoxia-related symptoms
- 7% - Signature requirements were not met
  - Medical records were not authenticated by the author
  - Medical records contain an illegible signature and no signature log or attestation statement was submitted
  - Medical records were dated with a date stamp
- 3% - Medical documentation did not demonstrate that beneficiary was tested in a chronic stable state
- 3% - 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

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 07/18/2014
Codes Billed: E1390, E0431

Documentation received: Written order prior to delivery signed and dated 7/16/14; physician progress note dated 7/15/14; initial CMN dated 7/18/14; proof of delivery date 7/18/14

Missing: Proof of receipt prior to delivery and a description of the DME item on the written order prior to delivery; documentation of the beneficiary's oxygen saturation at rest on room air prior to exercise

Example 2:
DOS 05/07/2014 - 07/07/2014
Code Billed: E1390

Documentation received: Discharge summary dated 2/20/14; prescription order dated 3/3/14; initial CMN dated 5/7/14; attestation letter dated 9/2/14; proof of delivery dated 3/3/14

Missing: Documentation of a physician visit dated within 30 days prior to the initial certification date; documentation of oximetry testing in the medical record to support the blood gas study results on the CMN; proof of delivery dated 5/7/14

Example 3:
DOS 05/21/2014 - 09/21/2014
Code Billed: E0431

Documentation received: Written order prior to delivery signed and received 5/20/14; illegible CMN; nurse note dated 5/17/14; proof of delivery dated 5/21/14; supplier forms

Missing: A detailed description of the item ordered on the written order prior to delivery; a legible copy of the initial CMN; documentation of an in-person visit with the treating provider

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**
  http://www.medicarenhic.com/dme/supmandownload.aspx
  Chapter 10 - Durable Medical Equipment, for additional information regarding coverage and documentation requirements
- **CERT Error Articles**
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Physician Letter - **Home Oxygen Initial Qualification Testing**
  http://www.medicarenhic.com/viewdoc.aspx?id=2667
- Physician Letter - **Face-to-Face and Written Order Requirements for High Cost DME**
  http://www.medicarenhic.com/viewdoc.aspx?id=2581
- **Frequently Asked Questions** (search word oxygen)
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- **Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)** **http://www.medicarenhic.com/dme/mrbulletinpca.aspx** (Posted 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; 111/05/2010; 06/09/2010).
- **Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390**
  http://www.medicarenhic.com/viewdoc.aspx?id=2692

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

1099-MISC Form Information (GEN)

NHIC, Corp. will mail all 1099 Forms for calendar year (CY) 2014 by January 31, 2015. Suppliers can expect 1099 Forms to arrive within 7-10 business days from the date of mailing.

NHIC, Corp. will issue a 1099 reflecting payments made on the Jurisdiction A Durable Medical Equipment Medicare Administrative Contract (DME MAC) by NCS/PTAN from NHIC for CY 2014.

For Example: *ABCD Pharmacy has 3 PTAN #'s then ABCD Pharmacy will receive 3 1099 forms*

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

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

Common Question/Concerns

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

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

What address will my 1099 be mailed to?

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

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

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

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

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

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

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

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

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

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

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

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

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

Billing Reminder for Glucose Monitors and Supplies - KS and KX Modifiers (SPE)

If a beneficiary is not treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted.

If a beneficiary is treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted.

The KX modifier must not be used for a beneficiary who is not treated with insulin injections.

Refer to the Glucose Monitor Policy for additional information: **http://www.medicarenhic.com/dme/mrlcdcurrent.aspx**

Presubmitted ACT Questions - ACT Call Questions and Answers - December 10, 2014 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Wednesday, December 10, 2014 as a teleconference / webinar and contained a brief presentation on the What's New and Hot Topics. The presentation was followed by an operator assisted Q&A session.

The POE team provided information on the following topics during the presentation portion of the ACT Call:

- **ACA Requirement for Indicating the Date of Receipt on Documentation** - Many questions have arisen from suppliers about what methods are acceptable for documenting a receipt date of the face-to-face exam and detailed written order for items affected by the ACA regulations. The DME MACs do not specify what method may be used to indicate date of receipt; however, there must be some indicator or notation on the documents that they were received by the supplier within the required time period. Some commonly accepted methods are hard-copy date stamps, hand-written dates, facsimile headers, and electronic receipt dates. If using a fax, the documents are often faxed back and forth between parties; therefore, it is important that the date of receipt be clear that it was received by the supplier on the date listed. Suppliers may want to include a copy of the fax coversheet if the header does not contain sufficient information to show the supplier was the party that received the fax on the date listed.

- **PMD Prior Authorization - Demonstration Process** - CMS announced the expansion of the PMD demonstration for the states of Maryland, New Jersey, and Pennsylvania. A review of the PMD Demonstration and its requirements were provided to the registrants. The expansion of the Prior Authorization demonstration was effective for 7-element orders written on or after October 1, 2014 for beneficiaries residing in Pennsylvania, Maryland, and New Jersey. The 7-element orders prior to October 1, 2014 are not eligible for the PAR process. A list of resources for the PMD PAR Demonstration are available on the highlights and headlines (**http://www.medicarenhic.com/dme/handh.aspx**) section of the NHIC web site.

- **Correction to Processing of Wheelchair Accessory Claims for Round 2 (CR8864)**
  Change Request 8864 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8864.pdf**) is a clarification of Change Request 8181 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8181.pdf**) that gave providers guidance regarding the CMS claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in a Competitive Bid Area. The CR will implement corrections within VIPs Medicare system (VMS) on January 5, 2015 and will be effective for claims processed on or after January 5, 2015. Suppliers with claims which are identified as either having been incorrectly paid allowable amounts to contract suppliers or denied to non-contract suppliers will need to submit a reopening request to the DME MAC's Reopening department. The request needs to include all affected PTANS and indicate whether the claims were denied or paid incorrectly.

Contract Suppliers must submit their requests after January 5, 2015 to ensure the claim will be paid at the appropriate payment rate. Non-contract suppliers may submit their claims prior to January 5th for proper adjudication. If it has been more than one year since the

claim was processed, the reopening should indicate if the supplier is requesting to waive timely filing by including the following or similar statement; "*KY Modifier Processing Issues resolved under CR 8864.*"

More information along with a list of policy scenarios and instructions on how to properly bill the claim is listed in CR8864 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8864.pdf**).

- **E2378 When Furnished for Use with a Complex Rehabilitative Power Wheelchair** - CR8566 provided instructions regarding the reclassification of certain DME items from the Inexpensive and Routinely Purchased DME payment category to the Capped Rental DME payment category. CMS has clarified that HCPCS code E2378, Power Wheelchair Component, Actuator, Replacement Only, was missing from the list of items billable with complex rehabilitative wheelchair codes K0835 - K0864.

Effective for dates of service on or after April 1, 2014, the E2378 is payable as a purchase when used with complex rehabilitative wheelchairs (K0835 - K0864). If E2378 was denied incorrectly for being billed as a purchase, a reopening can be submitted for reprocessing.

- *Standard Documentation Language Revision - Joint DME MAC Publication* (**http://www.medicarenhic.com/viewdoc.aspx?id=412**) - A Joint DME MAC Publication of the Standard Documentation Language revision was posted to the NHIC web site on October 30th. This version incorporates information on repairs in the Policy Specific Documentation Section of the LCDs. One revision was noted that a new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs. For repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. Documentation needed for Medicare reimbursement of repairs is:
    - The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary, and
    - Either the treating physician or the supplier must document that the repair itself is reasonable and necessary

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

- **PSP Portal Additional Feature** - The newest feature added to the portal is the ability to submit overpayment refunds along with checking the status of overpayment requests. More information on the portal can be found at the following link: NHIC Corp. Provider Services Portal (PSP) (**http://www.medicarenhic.com/dme/psphome.aspx**).

Note: *Individual claim specific questions, questions not general in nature, and questions that were incomplete are not included in this document. In addition, some questions may be rewritten to establish clarity. As advised during the call, please contact Customer Service to address individual questions.*

Q1: **My question is regarding proof of ATP involvement for Complex Rehab equipment (K5, E1161, Group 3 power, etc.). We have our ATP staff complete a wheelchair evaluation form that documents measurements, details of trial, etc. performed during the ATP evaluation. My question is the date that the ATP signs and dates their eval relevant? For example, if our ATP staff sign and date the form at the time of delivery is that acceptable? The actual ATP eval is completed prior to delivery, but the ATP staff normally sign and date the eval at the time of delivery showing that the process is complete.**

A1: As long as the evaluation is completed prior to delivery and is dated as such, then signing off upon completion should be acceptable. It is suggested the suppler has documentation of their procedure. There is information regarding ATP involvement in the FAQs located at: *Power Mobility Devices FAQ - Supplier ATP Involvement - Revised July 2010* (**http://www.medicarenhic.com/viewdoc.aspx?id=841**). The medical policy does not mandate how suppliers document compliance with the ATP requirement. There must be evidence in the supplier's file of direct in-person interaction with the patient by the ATP in the wheelchair selection process.

Q2: Please clarify the difference between when and the time frame in which a face-to-face must occur in the following scenarios:

(1) Patient switches insurances from Medicare HMO or private insurance to Fee-for-Service Medicare?

- The face-to-face must occur within 6 months prior to the Written Order Prior to Delivery. The exception for this is the PAP device which requires a face-to-face evaluation when entering FFS Medicare.

(2) The time frame of a face-to-face pertaining to oxygen contents delivery

- If contents were not listed on the original order, a new face-to-face within 6 months prior to the physician writing the order and a Written Order Prior to Delivery are required.

(3) Replacement equipment and/or Reasonable Useful Lifetime (RUL) is expired?

- A face-to-face evaluation is required within 6 months prior to the Written Order Prior to Delivery for the replacement item.

Q3: Often a patient will call and/or stop by the office in need of an emergency repair to either the prosthetic or orthotic device. Are we mandated to still get the dispensing prescription and clinical notes from a recent face-to-face appointment documenting the need for this repair, along with a detailed prescription before actually repairing the device?

A3: An order is not required for repairs. If the item was paid for by Medicare initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

- The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary. There must be documentation in the physician medical record within the past 12 months that supports continued need as stated in the Standard Documentation Language; and
- Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

Q4: If there is any writing under the bottom line of the ABN does it make the ABN invalid?

A4: It may invalidate the ABN. ABN's cannot be modified except as specifically allowed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 30 section 50.6.2 (**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf**) of the IOM. Section H of the ABN can be utilized by the supplier for additional information.

Q5: Can we permanently modify the ABN and add Print name & Representative in section H?

A5: Yes. Section H of the ABN is titled Additional Information. Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. More information on how to complete an ABN can be located on CMS' website under FFS ABN (**http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html**).

Q6: Can we permanently modify the ABN and add 'Items' to all Section D indicators except Section D blank box?

A6: Yes. The following descriptors may be used in the header of Blank (D): Item, Service, Laboratory test, Test, Procedure, Care, and Equipment. The exception is for the Blank D box. This is where the name of the item/equipment being provided is written in beneficiary friendly language so the beneficiary or their representative understands what item(s) they may be responsible for payment.

Q7: Please clarify the fee structure for non-par providers.

A7: Non-participating providers may bill the beneficiary for the difference of their cost and the Medicare allowable. There is no limiting charge for DME claims. Participating providers must accept the Medicare allowable as payment in full.

Q8: We bill E0486, there is no published fee although the allowance is approximately $1850 if a provider is non-par, can their full fee be collected from the patient (provider does not accept assignment) or is there a cap (15% over allowance) as allowable?

A8: There is no limiting charge for DME MAC claims. The supplier can bill their full submitted charge. This charge should be fairly consistent to other private pay customer charges and the rate charged to other insurances.

Q9: **Why can't the beneficiary's supplement insurance (cross over insurance) be listed when checking eligibility?**

A9: Currently this information is not available; however, suppliers can address any questions or suggestions with the PSP team via **nhicpspcommunications@hp.com**

Q10: **A speech pathology report has findings that the beneficiary has oral pharengyia dysphasia and recommends a regular diet (only sips and small bites) and enteral diet for the source of nutrition. Would the beneficiary qualify for enteral under this diagnosis?**

A10: Without all the documentation a definitive answer cannot be given. Normally if a beneficiary can eat small amounts and still sustain the nutritional level, enteral therapy would be noncovered.

Q11: **For beneficiaries with ALS, CVA, etc, and cannot manipulate bolus syringes or a gravity drip bag and do not have sufficient family support, would Medicare consider coverage of a pump?**

A11: The LCD lists "some" of the reasons a pump will be allowed but is not an all-inclusive list. If a supplier has documentation that the beneficiary cannot manipulate the gravity or syringe methods of administration, a pump would be considered.

Q12: **Medicare is allowing orthopedic shoes as a covered benefit if attached to an orthotic brace. If the brace is only allowed to be replaced every five years; however, shoes tend to wear out sooner, can we replace the shoes if we are not replacing the orthotic? Also, if a supplier did not provide the orthotic but now the shoe needs to be replaced, would it be considered for coverage?**

A12: Yes. This would fall under the repair rules and it would be considered for coverage. The shoes do not need to be replaced by the original supplier of the brace. When the supplier submits the claim it needs to have the RT and/or LT modifier as well as an RB modifier indicating the item is a replacement of a part of the base item (brace). The supplier would also need to have access to the documentation that supports the need of the base item and the shoe.

Q13: **We are required by Medicare to use the IVR to check a claim when it denies CO-109, SNF/Hospital. Will the portal have information on beneficiary status in a Skilled Nursing Facility or Hospital? The portal does not show the admission date or the NPI of the facility.**

A13: The PSP does not currently provide the NPI for SNF or hospital stays since it is not available via the CMS eligibility transaction. For PSP information, suppliers should contact the PSP Support Team via email at **nhicpspcommunications@hp.com**, or by calling 781-741-3192 and leaving a message. Support is available during normal business hours, Monday through Friday. NHIC is open to suggestions for additions to the portal and those suggestions can be made by contacting the helpdesk.

Q14: **When a beneficiary signs an ABN, is the estimated cost supposed to be the DME item per month or the estimated cost of the Medicare rate?**

A14: For a rental item, it would be the per month charge. Indicate that this cost is per month in the cost estimate field so the beneficiary is aware of what they will be responsible for each month. If it is a purchase item, it would be the full cost. If it is a non-assigned claim, it would be the suppliers full charge. If it is an assigned claim it would be the Medicare allowable amount,

Q15: **When a CPAP is rented and is over 5 years old and switches to a BIPAP, does the BIPAP need to meet compliance?**

A15: Per the PAP LCD: "*If an E0601 device has been used for more than 3 months and the beneficiary is switched to an E0470, a new initial face-to-face clinical evaluation is required, but a new sleep test is not required. A new 3 month trial would begin for use of the E0470.*" Thus, compliance would need to be demonstrated.

Q16: **If a beneficiary owns the infusion pump, does a supplier need a Written Order Prior to Delivery (WOPD) for the insulin supplies only?**

A16: A Detailed Written Order is only needed for the insulin supplies prior to claim submission. For any item that is on the ACA list such as the pump, a Written Order Prior to Delivery is required.

Q17: **What is a "rep payee" as referenced in the PMD Prior Authorization process?**

A17: It is similar to a power of attorney. The beneficiary can assign someone as a "rep payee" to handle their finances and medical decisions. In this situation, the exclusion to the PMD process for rep payees is due to the fact that claims are based on where the rep payee resides and not where the beneficiary actually lives which could be two different states.

Q18: **On the DWO for Oxygen, the route of administration and frequency of use must be listed. If this is on the Initial dispensing order or CMN , is that sufficient for lifetime?**

A18: Yes unless there is a change in the administration or frequency or if the initial order or CMN included a length of need that was less than lifetime.

Q19: **Please provide clarification on the oxygen contents fills after equipment has capped out. Example, if the item is not listed on the Initial or Recertification, then the patient must have a face-to-face within 6 months and a new WOPD obtained?**

A19: Yes. For any item on the ACA list (**http://www.medicarenhic.com/DME/face2face.aspx**), there must be a face-to-face exam within six months of the Written Order Prior to Delivery. Also, the supplier must receive both the face-to-face exam and WOPD prior to dispensing the item.

Q20: **Does the new WOPD for Oxygen also need to indicate frequency and route of administration?**

A20: Yes. All WOPDs must have all the required elements to be considered complete and valid.

Q21: **Would the recertification CMN be a valid WOPD if all the elements were listed?**

A21: Yes, the CMN can act as an order as long as Section C is sufficiently detailed with all required elements.

Q22: **If so, is this only valid for 1 year from the date of the Recertification?**

A22: It would be valid for the length of need listed on the CMN.

Q23: **Is the WOPD valid for one year for the oxygen contents?**

A23: The WOPD is valid for the length of need or number of refills specified. However, some state laws required yearly/periodic prescription renewal.

Q24: **Does the patient have to be seen every 6 months?**

A24: For oxygen, documentation of continued use and continued medical need must be documented within 12 months prior to the date of service in question.

Q25: **What if our WOPD is only valid for one year for an item on the ACA Face-to-Face list?**

A25: If a WOPD is only valid for one year and the beneficiary needs the item longer, a new WOPD is required and there must be a face-to-face exam within six months prior to the physician writing that order.

Q26: **What are the face-to-face requirements for replacement oxygen?**

A26: The supplier must meet the ACA requirements as well as the policy requirements. Whenever an item is replaced a new order is required. Since oxygen is being replaced and the HCPCS code is on the list of items in CR8304, a new face-to-face exam within six months prior to the new WOPD is required.

Q27: **When a beneficiary elects new equipment after the 5 year reasonable useful lifetime, who has title to the original oxygen equipment?**

A27: The original supplier still owns the equipment at the end of the 5 year reasonable useful lifetime.

Q28: What if the beneficiary wants to continue with the same equipment after the 60 month, what is status of the equipment in that scenario?

A28: The supplier's obligation to provide the oxygen equipment ends once the item reaches the five year reasonable useful lifetime. The supplier has the right to pick up their equipment in accordance with any state laws and regulations and require the beneficiary elect new equipment from their company or another company. If the supplier chooses to leave the equipment with the beneficiary the following rules would apply: If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier retains title to the equipment, all elements of the payment policy for months 37-60 remain in effect. There is no separate payment for accessories or repairs. If the beneficiary was using gaseous or liquid oxygen equipment during the 36th rental month, payment can continue to be made for oxygen contents.

If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier transfers title of the equipment to the beneficiary, accessories, maintenance, and repairs are statutorily noncovered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems.

Q29: Supplier expressed concerns regarding denials for E2311 and E2377 via the ADMC process based on the number of actuators billed.

A29: This issue is currently being researched by the NHIC Medical Director and Medical Review Manager and we will issue clarification once received.

Q30: For capped rental items that can also be purchased, if they are being replaced do suppliers need to obtain another capped rental/purchase option letter signed?

A30: Any item that falls into the capped rental payment category but the beneficiary chooses to purchase the item, suppliers need to obtain the capped rental/purchase option letter on file for either initial or replacement items.

Q31: We have been seeing an increase in auto cpap orders. Often times the sleep study does not include a CPAP titration but a base line only. Is a titration required for an auto cpap and non auto?

A31: The diagnostic study is acceptable as long as the results meet the current LCD requirements.

Q32: Who should be providing the detailed written order for a prosthesis. Is it the physiatrist that is providing the justification for the prosthesis or the primary care physician that ordered the prosthesis?

A32: The detailed written order should be provided by the physician that originally ordered the item. The additional documentation to support the need for the prosthesis would come from the physiatrist.

Q33: Since the DME MACs are not enforcing the face-to-face requirement, will claims deny because it is part of the documentation required per the LCD?

A33: NHIC is encouraging suppliers to be in full compliance with the ACA Face-to-Face requirements even though the DME MACs are not enforcing this requirement. However, there are other auditing contractors, i.e. CERT, that are enforcing this requirement. Keep in mind, the DME MACs are enforcing the Written Order Prior to Delivery (WOPD) requirement as well as the requirement for the NPI on the WOPD.

Q34: Is the chronic stable state requirement applicable to inpatient beneficiaries?

A34: The chronic stable state requirement does not apply to beneficiaries whom are inpatient at the hospital. If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date. This is an exception to the chronic stable state requirement and it does not apply to discharges from an inpatient nursing facility.

Q35: Is the exception only to the qualifying test or is it also applicable to the beneficiary's condition? Example, if the beneficiary entered the hospital with an acute problem and upon discharge the doctor ordered oxygen as the beneficiary's plan of care. Even if the condition presented in the emergency room is acute, is it applicable?

A35: No. The beneficiary must meet all additional policy criteria. The NCD requires the beneficiary have a severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm, or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy.

Q36: Can a podiatrist order a wheelchair, walker, or cane?

A36: It must be within the scope of their practice and also depends upon the state regulations. A podiatrist would not be able to order a wheelchair since there must be an assessment of the upper body. A walker or cane could possibly be ordered by a podiatrist as long as it fell within the scope of practice based on their state regulations.

Q37: Is a detailed written order for inatrope appropriate for refills if it states 12 months?

A37: Yes. The DWO would be good for one year of refills.

Q38: Does the NPI need to be on the DWO if the item is not on the ACA list?

A38: No. Only items on the ACA list need the NPI number on the written order prior to delivery.

Q39: Does the E0464 need to be invasive for Medicare to consider it for coverage?

A39: Ventilators are covered for life sustaining uses where, imminent harm would occur were the ventilator not to be used. Many conditions for which non-invasive ventilation is prescribed do not fall into this life sustaining category and therefore a ventilator would not be justified for payment. For non-invasive to be considered for coverage, it must meet the ventilator guidelines. It cannot be used as a PAP or RAD device. More information on the correct coding and billing of these items can be found in the article titled "Correct Coding and Coverage of Ventilators - Joint DME MAC Publication" which was posted to the NHIC DME MAC A Web site (**http://www.medicarenhic.com/dme/mrbulletincurrent.aspx**) on April 03, 2014

Q40: In what situations are wheelchairs options/accessories billed as a purchase vs. rental?

A40: Review the fee schedule (**http://www.medicarenhic.com/dme/dmfees.aspx**) to determine what payment category the items falls under. If it is under the Inexpensive or routinely purchased category, the item can be either purchased or rented. The supplier must give the beneficiary this option. If it falls under the capped rental category, normally the beneficiary would need to rent the item up to 13 months and then it would convert to a purchase. However, certain complex rehab wheelchair accessories have the option to purchase upfront.

Q41: What happens if a beneficiary purchases a wheelchair accessory but returns the wheelchair?

A41: The beneficiary keeps the purchase item and returns the rental item. Suppliers should make them aware of this up front so beneficiaries can make an informed decision as to whether they want to rent or purchase the item.

Q42: We have seen denials on claims from 2012 due to an inpatient stay. Why is Medicare going back to this date?

A42: Suppliers are required to keep records for a minimum of 7 years, therefore, a contractor could review records from seven years prior. These types of overpayments are most commonly identified by the Recovery Auditor (RA). The RA can go back 3 years from the date the claim was processed. The RA often times runs reports to catch vulnerabilities in the DME MACs system such as payments made to claims when the beneficiary was inpatient in a hospital.

Q43: If a RA requests an overpayment on the 36th month of oxygen rental, how do we get contents paid since the last rental was recouped and the rentals are now past timely filing?

A43: Suppliers can add another month for the rental period by billing for the most current billable monthly rental.

Reminder: Unique Tracking Number (UTN) Field Requirements - for Power Mobility Devices (PMD) (MOB)

The Power Mobility Devices (PMD) Unique Tracking Number (UTN) should be submitted only on claims for beneficiaries in the prior authorization (PA) Demonstration states of Maryland, New York, New Jersey, and Pennsylvania. The item must be a PMD HCPCS and not an accessory code.

The UTN field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field for hardcopy claims or in the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claims.

Claims submitted without blanks or valid data will be returned to the provider for correction.

Provider Services Portal (PSP) Eligibility & Other Features. Have you enrolled? (GEN)

The Provider Services Portal (PSP) is a great resource for DME MAC A suppliers. Enrolling in the PSP allows you to access beneficiary eligibility instantly. Information is right at your fingertips! There is no need to call the IVR or customer service. The PSP is available 24/7 except during scheduled maintenance windows. We encourage all interested suppliers to take advantage of this opportunity to increase efficiency via the use of our free web-based portal.

The PSP utilizes the CMS 270/271 transaction for eligibility transactions and we have 12 months of information on file. The PSP Eligibility lookup offers basic eligibility data and also detailed information for skilled nursing, inpatient hospital, hospice and home health services. Avoid claim denials by enrolling in the PSP today.

Available eligibility data:

- Basic beneficiary data including: HICN, name, gender, date of birth, address, date of death & active/inactive data
- Medicare Part A and Part B eligibility
- Physical, Speech and Occupational Therapy Caps for current & previous year
- Deductible met for the current & previous year
- Medicare Part C (MCO) & D enrollment
- Medicare Secondary Payer (MSP)
- Preventative Service including next eligible date and financial liability
- Inpatient Hospital spells including the date range, remaining days, copayment remaining days and DOEBA/DOLBA dates. (The exact admit/discharge dates are not available in the 270/271 HETs transaction)
- Skilled Nursing Facility (SNF) spells including the date range, remaining days, copayment remaining days and DOEBA/DOLBA dates. (The exact admit/discharge dates are not available in the 270/271 HETs transaction)
- Hospice data including start, end dates and NPI number
- Home Health Episodes including start and end dates, DOEBA/DOELBA dates, contractor name & number and the NPI of the home health agency

Additionally, PSP offers the following information through lookup transactions:

- Claim Status
- Standard Paper Remittance (SPR)
- Same/Similar
- Specific A, L, & V HCPCS Same/Similar Search PDF Link Graphic (66KB)
- Reopening and Redetermination Submission & Status
- Overpayment Refund form Submission & Status
- MR forms - ADMC and PMD-PAR Submission & Status

PSP functionality and enrollment questions can be submitted via email to: **nhicpspcommunications@hp.com** or call the PSP Helpdesk at 781-741-3192.

Don't miss this opportunity! **Sign up NOW! (http://www.medicarenhic.com/dme/psphome.aspx)**

Fourth Quarter 2014 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for October through December 2014, are provided in the following table.

Please Note: The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 - Rejected for relational field Information within the HCPCS	93,861	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	23,320	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	13,731	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.
X222.226.2300.HI01-2.030 - Invalid Information within the Primary diagnosis code	12,862	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.094.2010AA.REF02.050 - Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	10,429	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.351.2400.SV101-3.020 - This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	9,130	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.087.2010AA.NM109.030 - Invalid information in the Billing Provider's NPI	8,026	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.
X222.380.2400.DTP03.080 - Invalid Information within the Future date and Date(s) of service	7,616	The service start/from date is greater than the date this claim was received.
X222.380.2400.DTP03.090 - Invalid Information within the Date(s) of service	7,376	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.
X222.351.2400.SV101-7.020 - This Claim is rejected for relational field Information within the Detailed description of service	6,041	Description must be present when Procedure Code requires a description/additional information.

Fourth Quarter 2014 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the fourth quarter of 2014. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from October through December 2014.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	31,580
OA109, N418 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	12,524
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.	9,037
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.	3,940
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).	1,690
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.	1,439
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.	1,374
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.	834
CO 16, N265, N286 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	801
CO 16, M77 Missing/incomplete/invalid/inappropriate place of service.	**Item 24B** - Enter the appropriate place of service code. Identify the location, using a place of service code, for each item used or service performed.	614

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. The *Supplier Manual* is available to current suppliers via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Updates/Corrections Made:

In December of 2014 chapters 1, 3, 4, 5, 6, 7, 8 and 10 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

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.

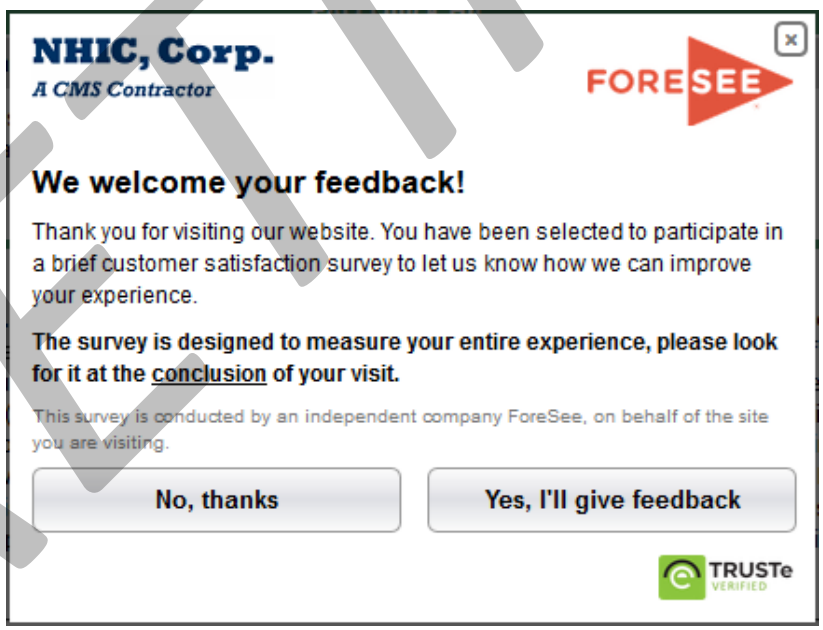
DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

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

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

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

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



For Your Notes

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

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

Faxed Reopenings: 781-741-3914 or 781-741-3842

Redetermination Requests Fax:

781-741-3118 **or** 781-741-3840

Redetermination Request Resulting from an Overpayment

781-383-4531

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Reconsiderations:
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Wilfred Mamuya, MD PhD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

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

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

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: **ngs.CEDIHelpdesk@wellpoint.com**

DME MAC Jurisdiction A Resource

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

March 2015
Number 35

Publication Information

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

Visit the following websites for more information:

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

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

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

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

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

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

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
Hingham, MA 02043