

DME MAC Jurisdiction A Resource

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

September 2015
Number 37

ICD-10

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)	4
FAQs - International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing (SE1435) (GEN)	8
Information and Resources for Submitting Correct ICD-10 Codes to Medicare (SE1518) (GEN)	10
Using the ICD-10-PCS New Technology Section X Codes (SE1519) (GEN)	12

General Information

Claim Status Category and Claim Status Codes Update (MM9276) (GEN)	15
Clarification of the Policy for Competitively-Bid Wheelchair Accessories Furnished with Non-Competitively Bid Wheelchair Base Equipment (MM9272) (MOB)	15
Classification of Speech Generating Devices (SGD) and Accessories under the Payment Category for Inexpensive or Routinely Purchased Durable Medical Equipment (MM9179) (SPE)	17
Healthcare Provider Taxonomy Codes (HPTCs) October 2015 Code Set Update (MM9260) (GEN)	18
Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE (MM9270) (GEN)	19
Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims (SE1521) (GEN)	19
Medicare Remit Easy Print (MREP) Upgrade (MM9203) (GEN)	21
National Site Visit Verification (NSV) Initiative (SE1520) (GEN)	21
New and Revised Place of Service Codes (POS) for Outpatient Hospitals (MM9231) (GEN)	23
Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims (SE1138) (GEN)	24
October 2015 Code Set Update October Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM9279) (GEN)	25
October 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9248) (DRU)	27
Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2015 Update (MM9167) (DRU)	28
Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2015 Update (MM9273) (DRU)	29
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2015 (MM9244) (GEN)	30
Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding - Authorized Officials Should Register Now (GEN)	31

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

<http://www.medicarenhic.com/dme/>

Table of Contents

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM9278) (GEN)	31
Update to Pub. 100-03, National Coverage Determination Manual, Chapter 1, Part 1, Section 50.1 Speech Generating Device (MM9281) (SPE)	34
Fee Schedule Updates (GEN)	35
CMS Mews Flash (GEN)	35
MLN Connects® Provider eNews (GEN)	37

Medical Review

DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps - Revised - Joint DME MAC Publication (GEN)	50
Draft Policies Released for Comment (GEN)	51
Surgical Dressings - Draft Policy Released for Comment (SPE)	53
Lower Limb Prosthesis Draft (July 2015) - Bibliography - Joint DME MAC Publication (O&P)	55
Coverage and Correct Coding of HYQVIA (Immune Globulin Infusion (Human) 10%, with Recombinant Human Hyaluronidase) - Revised - Joint DME MAC Publication (DRU)	57
Correct Coding - Modifiers - AU, AV, and AW - Joint DME MAC Publication (GEN)	58
Correct Coding - Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Correction Joint DME MAC Publication (O&P)	58
Parenteral Nutrition CERT Errors - Documentation Reminder - Joint DME MAC Publication (PEN)	65
PDAC Code Review - E0740 Non-Implantable Pelvic Floor Electrical Stimulator DME MAC Joint Publication (SPE)	66
Correct Coding - Surgical Dressings Containing Unclassified Materials - DME MAC Joint Publication (SPE)	67
LCD and Policy Article Revisions Summary for June 11, 2015 - Revised (GEN)	68
LCD and Policy Article Revisions Summary for June 25, 2015 (GEN)	70
LCD and Policy Article Revisions Summary for July 23, 2015 (DRU)	70
LCD and Policy Article Revisions Summary for August 20, 2015 (SPE)	71
Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (O&P)	71
Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (PEN)	74
Results of Widespread Prepayment Review for Milrinone (HCPCS Code J2260) (DRU)	76
Results of Widespread Prepayment Review for Nebulizers (HCPCS Code E0570) (SPE)	79
Results of Widespread Prepayment Review of Claims (Continuous Positive Airway Pressure Devices) HCPCS Code E0601 (SPE)	81
Results of Widespread Prepayment Review of Claims for Lumbar-Sacral Orthoses, HCPCS Codes L0631/L0637 (O&P)	85
Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (OXY)	87

Outreach & Education

Enhancements to the Interactive Voice Response System for Same and Similar Functionality A, L, and V Codes (GEN)	91
Affordable Care Act (ACA) 6407 - Supplier Frequently Asked Questions Joint DME MAC Article (GEN)	91
Second Quarter 2015 - Top Claim Submission Errors	95
Second Quarter 2015 - Top Return/Reject Denials	96
Supplier Manual News (GEN)	97
DME MAC A ListServes (GEN)	97
Quarterly Provider Update (GEN)	97
Updating Supplier Records (GEN)	98
DME MAC Jurisdiction A Web Site Customer Satisfaction Survey	98

Legend

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

AMA CPT / ADA CDT / AHA NUBC Copyright Statements

CPT only copyright 2002-2014 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The Code on Dental Procedures and Nomenclature (Code) is published in Current Dental Terminology (CDT). Copyright (c) American Dental Association. All rights reserved. CDT and CDT-2010 are trademarks of the American Dental Association.

UB-04 Manual. OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL, 2014, is copyrighted by American Hospital Association ("AHA"), Chicago, Illinois. No portion of OFFICIAL UB-04 MANUAL may be reproduced, sorted in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior express, written consent of AHA. Health Forum reserves the right to change the copyright notice from time to time upon written notice to Company.

MLN Matters Disclaimer

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

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 June 27, 2015, to clarify language under "Claims that Span the ICD-10 Implementation Date". All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Key Points of SE1408

General Reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to <http://www.cms.gov/Medicare/Coding/ICD10/index.html> for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General Claims Submissions Information

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

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

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

Claims that Span the ICD-10 Implementation Date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 - October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A - Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (<i>incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</i>)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through 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

ICD-10

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health - Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note
34X	Home Health - (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A - Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and 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

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
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.

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 June 9, 2015, to provide updated information for physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

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 the following:

- 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 want to change your selected submitter IDs, NPIs, PTANs, or HICNs, you must contact the MAC. If the MAC is not aware of these changes, claims submitted will 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 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 or April 2015 end-to-end testing, do I need to reapply for July 2015 testing?

No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. 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 the following MLN Matters® Articles:

- 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 (CMS) website;
- SE1408, “*Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492*,” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf> on the CMS website; and
- SE1410, “*Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015*,” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf> on the CMS 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 RTP editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the ERA, and they will not be available through Direct Data Entry (DDE). If claims accepted by the front end edits do not appear on the ERA, please contact the 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. Will a summary of test claims be provided at the conclusion of testing?

Yes, the MAC will provide testers a summary of all accepted test claims after the April and July testing rounds. These reports will be delivered to testers approximately 4 weeks following the testing week. Reports for April 2015 testing were delivered by May 29.

6. If a 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 October 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.

7. 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.

8. 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. MACs will set up NOEs for any hospice claims received during testing.

9. 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.

Information and Resources for Submitting Correct ICD-10 Codes to Medicare (SE1518) (GEN)

MLN Matters® Number: SE1518

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

Provider Types Affected

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

Provider Action Needed

This MLN Matters® Special Edition article is intended to assist physicians, providers, and suppliers by offering information and resources for submitting correct International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes to Medicare.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all *Health Insurance Portability and Accountability Act*-covered entities. ICD-10-CM, including the “ICD-10-CM Official Guidelines for Coding and Reporting,” will replace

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the “ICD-10-PCS Official Guidelines for Coding and Reporting,” will replace ICD-9-CM procedure codes.

Use of External Cause and Unspecified Codes in ICD-10-CM

Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a State-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity. If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

All the Medicare claims audit programs will use the same approach under ICD-10 as is used under ICD-9. Physicians, like all providers, are expected to code correctly and have sufficient documentation to support the codes selected. For example, if a physician is treating a patient for diabetes, there should be an ICD-10 code on the claim for diabetes. The level of specificity of the diabetes code selected will not change the coverage and payment of services in most cases.

Information and Resources

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

- General ICD-10-CM/PCS information: <http://www.cms.gov/Medicare/Coding/ICD10/index.html> on the Centers for Medicare & Medicaid Services (CMS) website;
- ICD-10 Fee-For-Service educational resources, including MLN Matters® articles, MLN products, MLN Connects® videos, and CMS resources: <http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html> on the CMS website;
- “Coding for ICD-10-CM: More of the Basics” MLN Connects® video: <http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences-Items/2014-12-02-ICD-10-Basics.html> on the CMS website;
- General Equivalence Mappings: <http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html> on the CMS website; and
- ICD-10 National Coverage Determinations: <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html> on the CMS website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html> on the CMS website.

Using the ICD-10-PCS New Technology Section X Codes (SE1519) (GEN)

MLN Matters® Number: SE1519

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

Provider Types Affected

This article is intended for all hospitals who submit inpatient claims to Medicare Administrative Contractors (MACs), for services provided to Medicare beneficiaries.

Provider Action Needed

This MLN Matters® Special Edition article is intended to assist hospital providers by offering details about the new International Classification of Diseases, Tenth Edition, Procedure Coding System (ICD-10-PCS) Section X New Technology, as well as specific coding instruction for the new section.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all *Health Insurance Portability and Accountability Act*-covered entities. ICD-10-CM, including the “ICD-10-CM Official Guidelines for Coding and Reporting,” will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the “ICD-10-PCS Official Guidelines for Coding and Reporting,” will replace ICD-9-CM procedure codes. ICD-10-PCS will be used for reporting inpatient hospital procedures.

Section X New Technology - General Information

Section X New Technology is a section added to ICD-10-PCS beginning October 1, 2015. The new section provides a place for codes that uniquely identify procedures requested via the New Technology Application Process or that capture other new technologies not currently classified in ICD-10-PCS.

Section X was created in response to public comments received regarding New Technology proposals presented at ICD-10 Coordination and Maintenance Committee Meetings, and general issues facing classification of new technology procedures. The public had opposed many requests to add new codes to the existing ICD-10-PCS sections for the use of specific drugs, devices, or supplies in an inpatient setting, even when the code related to an application for New Technology add-on payments.

The new section is simply a separate place for certain new technology procedures, such as infusion of new technology drugs, and was created because the public did not support adding any more of these types of codes to the other sections of ICD-10-PCS. Section X does not introduce any new coding concepts or unusual guidelines for correct coding. In fact, Section X codes maintain continuity with the other sections in ICD-10-PCS by using the same root operation and body part values as their closest counterparts in other sections of ICD-10-PCS. For example, the two new codes for the infusion of ceftazidime-avibactam, a new technology antibiotic that requires unique procedure codes for October 1, 2015, use the same root operation (Introduction) and body part values (Central Vein and Peripheral Vein) in section X as the infusion codes in section 3 Administration, which are their closest counterparts in the other sections of ICD-10-PCS.

In ICD-10-PCS, the information specified in the seventh character is called the qualifier, and the type of information specified depends on the section. In section X, the seventh character is used exclusively to indicate the new technology group.

The New Technology Group is a number or letter that changes each year that new technology codes are added to the system. For example, Section X codes added for the first year have the seventh character value 1, New Technology Group 1, and the next year that Section X codes are added have the seventh character value 2, New Technology Group 2, and so on. This is a much simpler use of the qualifier than in many other sections of ICD-10-PCS, such as the Medical and Surgical section.

Because it is only used to indicate the update year the code was created, there are no special coding instructions or requirements for the use of the qualifier, because all codes for a particular new technology procedure will all have the same qualifier. Therefore, the New Technology Group has no impact for correct coding. Its function is to allow the section to maintain consistency between the root operation and body part values of the other sections, as described above, and to allow the section to evolve over time, as medical technology evolves.

Section X Coding Instruction

Section X codes are standalone codes. They are not supplemental codes. Section X codes fully represent the specific procedure described in the code title, and do not require any additional codes from other sections of ICD-10-PCS. When section X contains a code title which describes a specific new technology procedure, only that X code is reported for the procedure. There is no need to report a broader, non-specific code in another section of ICD-10-PCS.

For example, code XW04321 Introduction of Ceftazidime-Avibactam Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 1, would be reported to indicate that Ceftazidime-Avibactam Anti-infective was administered via central vein. A separate code from table 3E0 in the Administration section of ICD-10-PCS would not be reported in addition to this code. The X section code fully identifies the administration of the ceftazidime-avibactam antibiotic, and no additional code is needed.

The New Technology section codes are easily found by looking in the ICD-10-PCS Index or the Tables. In the Index, the name of the new technology device, substance or technology for a section X code is included as a main term. In addition, all codes in section X are listed under the main term New Technology. The new technology code index entry for ceftazidime-avibactam is shown below.

Ceftazidime-Avibactam Anti-infective XW0
New Technology
 Ceftazidime-Avibactam Anti-infective XW0

In the Tables, New Technology codes are displayed like all other ICD-10-PCS tables, with a separate table for each root operation and body system. All section X codes for the root operation Introduction valid for October 1, 2015, are shown in the table below.

<i>Section</i>	X	New Technology	
<i>Body System</i>	W	Anatomical Regions	
<i>Operation</i>	0	Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products	
<i>Body Part</i>		<i>Approach</i>	<i>Device / Substance / Technology</i>
3 Peripheral Vein 4 Central Vein		3 Percutaneous	2 Ceftazidime-Avibactam Anti-infective 3 Idarucizumab, Dabigatran Reversal Agent 4 Isavuconazole Anti-infective 5 Blinatumomab Antineoplastic Immunotherapy
			1 New Technology Group 1

Information and Resources

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

- General ICD-10-CM/PCS information: <http://www.cms.gov/Medicare/Coding/ICD10/index.html> on the Centers for Medicare & Medicaid Services (CMS) website;
- ICD-10 Fee-For-Service educational resources, including MLN Matters® articles, MLN products, MLN Connects® videos, and CMS resources: <http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html> on the CMS website;
- General Equivalence Mappings: <http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html> on the CMS website; and

- ICD-10 National Coverage Determinations: <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html> on the CMS website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html> on the CMS website.

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!

Claim Status Category and Claim Status Codes Update (MM9276) (GEN)

MLN Matters® Number: MM9276
Related CR Release Date: August 28, 2015
Related CR Transmittal #: R3344CP

Related Change Request (CR) #: CR 9276
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9276 informs MACs about the changes to the Claim Status Category and Claim Status Codes.

Background

The *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/> and <http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/> on the Internet. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

All code changes approved during the September/October 2015 committee meeting will be posted on those sites on or about November 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR9276.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9276.

Additional Information

The official instruction, CR9276 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3344CP.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.

Clarification of the Policy for Competitively-Bid Wheelchair Accessories Furnished with Non-Competitively Bid Wheelchair Base Equipment (MM9272) (MOB)

MLN Matters® Number: MM9272
Related CR Release Date: August 14, 2015
Related CR Transmittal #: R3324CP

Related Change Request (CR) #: CR 9272
Effective Date: July 1, 2013
Implementation: January 4, 2016

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for competitively-bid wheelchair accessories furnished with non-competitively bid wheelchair base equipment provided to Medicare beneficiaries.

General Information

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9272 as a clarification regarding 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 competitive bidding areas (CBAs). As a result of this clarification, you may need to resubmit certain claims that Medicare previously denied. See the Background section of this article for more detailed information on the claims you may need to resubmit.

Background

The Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) was established by section 302(b)(1) of the *Medicare Prescription Drug, Improvement, and Modernization Act* of 2003 (MMA) (Pub. L. 108-173). This publication amended section 1847 of the *Social Security Act* (the Act) to require the Secretary to establish and implement programs under which CBAs are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

Currently, if a supplier submits an unassigned claim for a competitively bid accessory (identified by a Healthcare Common Procedural Coding System (HCPCS) code) that is used on a non-competitively bid base, the claim is denied because Competitive Bidding Program editing in the shared systems requires claims with CBP items to be assigned. This CR9272 adjusts that process.

With CR9272, the “Medicare Claims Processing Manual,” Chapter 36, Competitive Bidding, Section 50.16 “Exception for Wheelchair Accessories Furnished with Non-Competitively Bid Wheelchair Base Equipment” is revised to state that effective for claims with dates of service on or after July 1, 2013, competitively bid wheelchair accessories are paid in accordance with standard Medicare DMEPOS payment rules, not competitive bidding rules, when furnished with non-competitively bid wheelchair base equipment (see CR 8864, Transmittal 1420, issued on August 15, 2014, for applicable HCPCS codes). (To review MLN Matters® Article 8864, you may visit

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8864.pdf> on the CMS website.)

Medicare will allow an unassigned claim under the following conditions:

- The item is a competitively bid wheelchair accessory that is used with a non-competitively bid wheelchair base; AND
- The KY modifier is submitted with the claim.

Your DME MAC will reprocess claims that were either incorrectly paid or denied in error for dates of service between the effective date, July 1, 2013, and implementation date of CR9272 when you resubmit such claims within 6 months from the implementation of CR9272. Your DME MAC will override the timely filing edits for these resubmitted claims.

Suppliers that billed directly to the beneficiary and received payment for these claims must resubmit and give beneficiaries the applicable overpayments.

Additional Information

The official instruction, CR 9272, issued to your MAC regarding this change is available at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3324CP.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?

Classification of Speech Generating Devices (SGD) and Accessories under the Payment Category for Inexpensive or Routinely Purchased Durable Medical Equipment (MM9179) (SPE)

MLN Matters® Number: MM9179

Related CR Release Date: June 12, 2015

Related CR Transmittal #: R1511OTN

Related Change Request (CR) #: CR 9179

Effective Date: October 1, 2015

Implementation Date: October 5, 2015

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 9179, which provides instructions to MACs to change the DME payment category for SGDs and accessories essential for the effective use of the SGD from capped rental (CR) to inexpensive or routinely purchased (IN), effective for SGD and their accessories furnished between October 1, 2015, through September 30, 2018.

Effective for claims with dates of service on or after October 1, 2015, if the beneficiary opts to purchase the SGD, MACs will deduct the cumulative allowed amount for any and all previously paid claims for the item from the allowed amount for the purchase of the item so that payment for purchase of the item does not exceed the fee schedule amount for purchase of the equipment.

Background

Change Request 9179 provides instructions regarding the recent amendment of [Section 1834\(a\)\(2\)\(A\)](#) of the Act, that changes the payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015, and September 30, 2018, from capped rental to inexpensive or routinely purchased.

As a result of the amendment, SGDs (and their accessories) furnished between October 1, 2015, and September 30, 2018, are now classified as inexpensive or routinely purchased items and subject to the payment rules outlined in Section 1834(a)(2) of the Act. Items in this payment category are paid on a purchased new (NU), purchased used (UE) or rental (RR) basis. Total payments for items in this category (sum of allowed charges for all claims for rental or purchase) may not exceed the fee schedule amount for purchase of NU.

Note: The NU, UE or RR fee schedule amounts for the SGD and accessory codes will be provided on the October 2015 DMEPOS fee schedule update.

Additional Information

The official instruction, Change Request 9179, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1511OTN.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” on the CMS website.

General Information

Healthcare Provider Taxonomy Codes (HPTCs) October 2015 Code Set Update (MM9260) (GEN)

MLN Matters® Number: MM9260

Related Transmittal #: R3336CP

Effective Date: October 1, 2015

Related CR Release Date: August 21, 2015

Change Request (CR) #: 9260

Implementation Date: January 4, 2016 - Contractors with the capability to do so shall implement this CR effective October 1, 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.

What You Need to Know

Change Request (CR) 9260 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and 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 9260 implements the NUCC HPTC code set that is effective on October 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 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 issued to your MAC regarding this change is available at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3336CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE (MM9270) (GEN)

MLN Matters® Number: MM9270
Related CR Release Date: August 21, 2015
Related CR Transmittal #: R3335CP

Related Change Request (CR) #: CR 9270
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9270 instructs MACs to update systems based on the CORE 360 Uniform Use of CARC and RARC Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2015.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set, required by January 1, 2014, by the *Affordable Care Act*.

CR9270 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2015. This update is based on July 1, 2015 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website. (Visit <http://www.wpc-edi.com/reference> for CARC and RARC updates and <http://www.caqh.org/CORECodeCombinations.php> for CAQH CORE defined code combination updates.)

Additional Information

The official instruction, CR9270 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3335CP.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.

Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims (SE1521) (GEN)

MLN Matters® Number: SE1521
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 physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

General Information

What You Need to Know

This Special Edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and Qualified Independent Contractors (QICs) regarding the scope of review for redeterminations (Technical Direction Letter-150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after August 1, 2015, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a post-payment review or audit, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a Zone Program Integrity Contractor (ZPIC), Recovery Auditor, MAC, or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. If an appeal involves a claim or line item denied on a pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or Correct Coding Initiative edits) will result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after August 1, 2015. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

Additional Information

You can find out more about appealing claims decisions in the “*Medicare Claims Processing Manual*” (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), Section 310.4.C.1. (Conducting the Redetermination (Overview)) at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf> on the CMS website.

You can also find out more about 1) conducting a redeterminations in 42 CFR 405.948, at http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948; and 2) conducting a reconsideration in 42 CFR 405.968 at http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968 on the Internet.

Medicare Remit Easy Print (MREP) Upgrade (MM9203) (GEN)

MLN Matters® Number: MM9203
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R1524OTN

Related Change Request (CR) #: CR 9203
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

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

This article is based on Change Request (CR) 9203. MREP software was developed by the Centers for Medicare & Medicaid Services (CMS) to help providers transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR9203 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. The key change in this latest version of the software is an enhancement to the MREP application to suppress the PR group code (Patient Responsibility) from the glossary of the Entire Remittance Report when the only Patient Responsibility items on the claim are for Claim Adjustment Reason Code (CARC) 01 (deductible) and CARC 02 (co-insurance). Make sure that your billing staffs are aware of these changes.

Additional Information

The official instruction, CR9203 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1524OTN.pdf> on the CMS website.

More details about the free software, including instructions for downloading the software, are available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint.html> 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?

National Site Visit Verification (NSV) Initiative (SE1520) (GEN)

MLN Matters® Number: SE1520
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 providers and suppliers, that enroll in the Medicare program and submit fee-for-service (FFS) claims to Medicare Administrative Contractors (MACs), including home health and hospice MACs, for services provided to Medicare beneficiaries.

What You Need to Know

This article provides the latest information about the Centers for Medicare & Medicaid Services (CMS) National Site Visit Verification (NSV) initiative. The NSV initiative is part of CMS' National Fraud Prevention Program (NFPP) and assists CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process.

General Information

Key Information

National Fraud Prevention Program (NFPP)

The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP enables CMS to proactively identify and respond to suspicious behavior, thus making the Agency more effective at fighting health care fraud than ever before. The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process by:

- identifying and preventing bad actors from enrolling in Medicare;
- identifying and removing bad actors that are already in the program; and
- identifying and preventing payment of fraudulent claims by responding with quick administrative action (e.g. enrollment revocations or payment suspensions).

National Site Visit Contractor: Ensuring Program Integrity at the Provider Enrollment Stage

In 2011, CMS implemented a site visit verification program using a National Site Visit Contractor (NSVC). The site visit verification program is a screening mechanism to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The NSVC will conduct unannounced site visits for Medicare Part A/B providers and suppliers. Site visits for Durable Medical Equipment (DMEPOS) suppliers and providers will continue to be conducted by the National Supplier Clearinghouse. The NSVC may conduct either an observational site visit or a detailed review to verify enrollment related information and collect specific information based on pre-defined checklists and procedures determined by CMS.

During an observational visit, the inspector engages in minimal contact with the provider or supplier and does not inhibit the daily activities that occur at the facility. The inspector may take photographs of the facility as part of the site visit. During a detailed review, the inspector will enter the facility, speak with staff, take photographs, and collect information to confirm the provider or supplier's compliance with CMS standards.

MSM Security Services, LLC was awarded the national site visit contract December 20, 2011. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits. Inspectors performing the site visits will be employees of MSM, CES, or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

If the provider and/or its staff want to verify that a site visit has been ordered by CMS, please contact the respective jurisdiction's Medicare Administrative Contactor (MAC). MAC contact information can be found at

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf located on the CMS website.

If the provider and/or its staff wish to verify that an inspector is credentialed to complete a site visit verification, please call MSM Security Services, Monday through Friday from 7:00 a.m. to 8:00 p.m. ET at 1-855-220-1071. After 8 p.m., you may leave a message and the call will be returned the next business day.

Additional Information

To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" web page at

http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp on the CMS website.

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

New and Revised Place of Service Codes (POS) for Outpatient Hospitals (MM9231) (GEN)

MLN Matters® Number: MM9231
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3315CP

Related Change Request (CR) #: CR 9231
Effective Date: January 1, 2016
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9231, from which this article is taken, updates the “Medicare Claims Processing Manual” by:

- Revising the current Place of Service (POS) code set by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to “On Campus-Outpatient Hospital;” and
- Making minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility).

You should ensure that your billing staffs are aware of these POS code changes.

Background

As a *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) covered entity, Medicare must comply with HIPAA’s standards and their implementation guides. The currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains.

The POS code set provides care-setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for code specificity than Medicare, and many of the past years’ new codes that have been developed to meet Medicaid’s needs.

While Medicare does not always need this greater specificity in order to appropriately pay claims; it nevertheless adjudicates claims with the new codes to ease coordination of benefits, and to give Medicaid and other payers the setting information that they require. Therefore, as a payer, Medicare must be able to recognize any valid code from the POS code set that appears on the HIPAA standard claim transaction.

Therefore, in response to the discussion in the CY 2015 Physician Fee Schedule (PFS) final rule with comment period published on November 13, 2014 (79 FR 67572); in order to differentiate between on-campus and off-campus provider-based hospital departments, CMS is creating a new POS code (POS 19) and revising the current POS code description for outpatient hospital (POS 22).

CR 9231, from which this article is taken, provides this POS code update, effective January 1, 2016. Specifically, CR 9231 updates the current POS code set by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to “On Campus-Outpatient Hospital” as described in the following table.

New and Revised POS Codes Effective January 1, 2016

Code	Descriptor
POS 19 Off Campus-Outpatient Hospital	Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS 22 On Campus-Outpatient Hospital	Descriptor: A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

General Information

CR9231 also:

- Implements the systems and local contractor level changes needed for Medicare to adjudicate claims with the new and revised codes (your B MAC or DME MAC will develop policies as needed to edit and adjudicate claims that contain these new/revised codes according to Medicare national policy); and
- Makes minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility) by adding those two codes back into the POS list in the “Medicare Claims Processing Manual.” Those two codes were removed inadvertently from a prior version of that manual.

Additional Information Related to POS Codes 19 and 22

- Payments for services provided to outpatients who are later admitted as inpatients within 3 days (or, in the case of non-IPPS hospitals, 1 day) are bundled when the patient is seen in a wholly owned or wholly operated physician practice. The 3-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient’s inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. The 3-day payment rule will also apply to services billed with POS code 19.
- Claims for covered services rendered in an Off Campus-Outpatient Hospital setting (or in an On Campus-Outpatient Hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.
- Reporting outpatient hospital POS code 19 or 22 is a minimum requirement to trigger the facility payment amount under the PFS when services are provided to a registered outpatient. Therefore, you should use POS code 19 or POS code 22 when you furnish services to a hospital outpatient regardless of where the face-to-face encounter occurs.
- Your MACs will allow POS 19 to be billed for G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) and G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) in the same way as those services are billed with POS code 22.

Additional Information

The official instruction, CR9231, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.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.

Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims (SE1138) (GEN)

MLN Matters® Number: SE1138 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 June 22, 2015, to delete the last two sentences of the “Background” section on page 2. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

The Office of E-Health Standards and Services (OEHS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012. The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required. Please make certain your billing and coding staff follow

these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

Background

The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: “Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name”. If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I - 005010X223A2 and 837P - 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional Information

For 5010/D.O implementation information and deadlines, refer to MLN Matters® Special Edition Article #SE1131, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1131.pdf> on the CMS website.

If you are not ready, consider contacting your Medicare contractor to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at http://www.cms.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, Change Request (CR) 7392, “Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates,” dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

October 2015 Code Set Update October Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM9279) (GEN)

MLN Matters® Number: MM9279
Related CR Release Date: August 14, 2015

Related Transmittal #: R3323CP

Change Request (CR) #: CR 9279
Effective Date: January 1, 2015 (for implementation of fee schedule amounts for codes in effect on January 1, 2015; October 1, 2015 for all other changes)
Implementation Date: October 5, 2015

Provider Types Affected

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

General Information

Provider Action Needed

Change Request (CR) 9279 alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2015. Make sure your billing staffs are aware of the changes.

Background

The DMEPOS fee schedule are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in Pub.100-04, "Medicare Claims Processing Manual," Chapter 23, Section 60, found here <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf> on the CMS website.

The recurring update notification provides instructions regarding the October quarterly update for the 2015 DMEPOS fee schedule. Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the *Social Security Act*. Payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for Parenteral and Enteral Nutrition (PEN), splints and casts, and Intraocular Lenses (IOLs) inserted in a physician's office.

As part of the October 2015 update, fee schedules are established for the following two Healthcare Common Procedure Coding System (HCPCS) codes added to the HCPCS file effective January 1, 2005:

- E0639 - Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories, and
- E0640 - Patient lift, fixed system includes all components/accessories.

The fee schedule amounts for both codes were established using fees for comparable items in accordance with the instructions found in the "[Medicare Claims Processing Manual](#)," Chapter 23, Section 60.3. An average of the existing hydraulic or mechanical patient lift code E0630 and the electric patient code E0635 were used to establish the fee schedules for the hydraulic or electric patient lifts described under E0639 and E0640. The fee schedules for E0639 and E0640 are effective for dates of service on or after January 1, 2015. This update also revises the type of service code for HCPCS codes E0639 and E0640 from "9" to type of service code "R".

CR9279 also provides revised fee schedules for speech generating device (SGD) HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 per the recent amendments to Section 1834(a)(2)(A) of the *Social Security Act*. The *Steve Gleason Act* of 2015 was signed by the President on July 30, 2015 and changes the DME payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015 and September 30, 2018, from capped rental (CR) to inexpensive or routinely purchased (IN). Instructions relating to the implementation of the SGD amendments to Section 1834(a)(2)(A) were issued in Change Request 9179, dated June 12, 2015. The NU, UE, and RR fee schedule amounts for codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 are being added to the fee schedule file as part of this update.

The MLN Matters® Article related to CR9179 is available at

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9179.pdf> on the CMS website.

Additional Information

The official instruction, CR9279, issued to your MAC regarding this change is available at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3323CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

October 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9248) (DRU)

MLN Matters® Number: MM9248
Related CR Release Date: July 10, 2015
Related CR Transmittal #: R3290CP

Related Change Request (CR) #: CR 9248
Effective Date: October 1, 2015
Implementation Date: October 5, 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) 9248 which instructs MACs to download and implement the October 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the July 2015, April 2015, January 2015, and October 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 October 5, 2015, with dates of service October 1, 2015, through December 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The 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 OPPI 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 OPPI)), Section 50 (Outpatient PRICER)).

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

Files	Effective Dates of Service
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014

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

Additional Information

The official instruction, CR9248 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3290CP.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.

General Information

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

MLN Matters® Number: MM9167
Related CR Release Date: July 10, 2015
Related CR Transmittal #: R3292CP

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

Note: This article was revised on July 20, to reflect the revised CR9167 issued on July 10. In the article, language has been modified to clarify the use of Q9977. Also, the CR release date, transmittal number, and the Web address for accessing CR9167 are revised. On July 22, 2015, the article was revised further to include additional language from the revised CR9167. This additional language is in the note box on page 3 of this article. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS Codes. CR9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the “Claims Processing Manual” to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of New HCPCS Codes in CR9167

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

Table 1 - New HCPCS Codes in CR9167

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

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

CR9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the “Medicare Claims Processing Manual” to address the use of a compounded drug NOC code on claims for compounded drugs.

Please note: The new compounded drug code, Q9977 - Compounded Drug, Not Otherwise Classified, is not a replacement for existing codes. It is intended to distinguish compounded drugs (which may include biologicals) from other “not otherwise classified” codes such as J3490, J3590, J7799, J9999 and existing specific codes for compounded nebulized drugs. The implementation of Q9977 as a means of identifying compounded drug claims does not affect existing payment policy for compounded drugs as outlined in the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.2.

Additional Information

The official instruction, CR 9167 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3292CP.pdf> on the CMS website.

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

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2015 Update (MM9273) (DRU)

MLN Matters® Number: MM9273
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3304CP

Related Change Request (CR) #: CR 9273
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9273 informs the MACs that, effective for claims with dates of service on or after October 1, 2015, new Healthcare Common Procedure Coding System (HCPCS) code Q9979 (INJECTION, ALEMTUZUMAB, 1 MG) will be payable for Medicare. Make sure that your billing staff are aware of these changes.

Background

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. Change Request (CR) 9273 instructs that, effective for claims with dates of service on or after October 1, 2015, HCPCS code Q9979 will be established for alemtuzumab (Lemtrada) and will be payable for Medicare. See the following table for details regarding this temporary HCPCS code:

HCPCS Code	Short Description	Long Description	Type of Service (TOS) Code	Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator
Q9979	Injection, Alemtuzumab	Injection, Alemtuzumab, 1 mg	1, P	E

Additional Information

The official instruction, CR 9273, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3304CP.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.

General Information

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2015 (MM9244) (GEN)

MLN Matters® Number: MM9244
Related CR Release Date: August 6, 2015
Related CR Transmittal #: R3308CP

Related Change Request (CR) #: CR 9244
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9244 to provide the DMEPOS, CBP October, 2015, quarterly update. CR9244 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are also available at <http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home> on the Internet. At that site, click on the quarterly updates link on the left of the page.

Background

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

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

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

Additional Information

The official instruction, CR 9244 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3308CP.pdf> on the CMS website.

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

There are a number of products in the MLN Catalogue of Products that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.

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

Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding - Authorized Officials Should Register Now (GEN)

Registration is now open to all suppliers interested in participating in Round 1 2017 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to submit a bid, you are required to register in CMS' *Enterprise Identity Management (EIDM)* system to obtain a user ID and password to access the online DMEPOS bidding system (DBidS).

Designate one individual listed as an authorized official (AO) on your organization's CMS-855S enrollment application in the Provider Enrollment, Chain and Ownership System (PECOS) to act as your AO for registration purposes. The AO must be the first person in the organization to register in EIDM. After an AO successfully registers, other individuals listed as an AO on the CMS-855S in PECOS may register as back-up authorized officials (BAOs). The AO must approve a BAO's request to register. For the AO and BAOs to register successfully, the name and Social Security number entered in EIDM must match exactly with what is recorded on the CMS-855S and on file in PECOS. Individuals not listed as an AO on the CMS-855S in PECOS may only register to serve as end users (EUs). The AO or a BAO must approve an EU's request to register. Bidders are prohibited from sharing user IDs and passwords.

We strongly urge all AOs to register no later than September 21, 2015, to ensure that BAOs and EUs have time to register. We recommend that BAOs register no later than October 19, 2015, so that they will be able to assist AOs with approving EU registration before bidding begins on October 15, 2015.

Registration has been extended and will close on Friday, November 20, 2015, at 9pm prevailing ET - *no AOs, BAOs, or EUs can register after registration closes*. You will not be able to bid if you do not register on time. *Bidding will close on Wednesday, December 16, 2015.*

Register by clicking on *REGISTRATION IS OPEN* above the Registration clock on the [Competitive Bidding Implementation Contractor \(CBIC\)](#) website. We strongly recommend that you review the [EIDM Reference Guide](#) and [EIDM: Getting Started Registration Checklist](#).

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for "[E-mail Updates](#)" on the home page of the CBIC website. For information about Round 1 2017, please refer to the bidder education materials located under "Bidding Suppliers" on the CBIC [Round 1 2017](#) web page. The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the *Educational Information* section of the Round 1 2017 page.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 877-577-5331. During registration and bidding periods, the customer service center will be open between 9am - 7pm prevailing ET, Monday through Friday. Hours are extended to 9pm prevailing ET during the last two weeks of the registration and bidding windows.

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

MLN Matters® Number: MM9278
Related Transmittal #: R3298CP
Effective Date: October 1, 2015

Related CR Release Date: August 6, 2015
Change Request (CR) #: CR 9278
Implementation Date: October 5, 2015

Provider Types Affected

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

General Information

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. If any new or modified code has an effective date past the implementation date specified in CR9278, MACs must implement on the effective date found at the WPC website.

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

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

Changes in RARC List Since CR9125

New Codes - RARC

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

Modified Codes - RARC

Code	Modified Narrative	Effective Date
M47	Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	07/01/2015

Code	Modified Narrative	Effective Date
MA74	ALERT: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	07/01/2015
N432	ALERT: Adjustment based on a Recovery Audit.	07/01/2015
N22	ALERT: This procedure code was added/changed because it more accurately describes the services rendered.	07/01/2015
M39	ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	07/01/2015
M109	ALERT: This claim/service was chosen for complex review.	07/01/2015
M38	ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	07/01/2015
N381	ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	07/01/2015
MA91	ALERT: This determination is the result of the appeal you filed.	07/01/2015

Deactivated Codes - RARC

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

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

Changes in CARC List Since CR9125**New Code - CARC**

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

Modified Code - CARC

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

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

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

Additional Information

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

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

General Information

Update to Pub. 100-03, National Coverage Determination Manual, Chapter 1, Part 1, Section 50.1 Speech Generating Device (MM9281) (SPE)

MLN Matters® Number: MM9281

Related CR Release Date: August 21, 2015

Related CR Transmittal #: R184NCD

Related Change Request (CR) #: CR 9281

Effective Date: July 29, 2015

Implementation Date: September 21, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9281 updates the Medicare “National Coverage Determinations Manual” to add a revised scope of benefit National Coverage Determination (NCD) for Speech Generating Devices (SGDs) covered under the Medicare benefit category for Durable Medical Equipment (DME). Please make sure that your billing staff are aware of these changes.

Background

Key information in the revised NCD in Chapter 1 of the Manual is as follows:

SGDs are considered to fall within the Durable Medical Equipment (DME) benefit category established by Section 1861(n) of the *Social Security Act*. They are covered for patients who suffer from a severe speech impairment and have a medical condition that warrants the use of a device based on the following definitions.

SGDs are defined as DME that provide an individual who has a severe speech impairment with the ability to meet his or her functional, speaking needs. Speech Generating Devices are devices or software that generate speech and are used solely by the individual who has a severe speech impairment. The speech is generated using one of the following methods:

- digitized audible/verbal speech output, using prerecorded messages;
- synthesized audible/verbal speech output which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;
- synthesized audible/verbal speech output which permits multiple methods of message formulation and multiple methods of device access; or
- software that allows a computer or other electronic device to generate audible/verbal speech.

Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to “speak” or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

If an SGD is limited to use by a patient with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for the device to be dedicated only to audible/verbal speech output to be considered DME. Computers and tablets are generally not considered DME because they are useful in the absence of an illness or injury.

Nationally Non-Covered Indications

Internet or phone services or any modification to a patient’s home to allow use of the SGD are not covered by Medicare because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of an SGD that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not covered. This would include any computing hardware or software not necessary to allow for generation of speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly related to meeting the functional speaking communication needs of the patient, including video communications or conferencing. These features of a speech generating device do not fall within the scope of Section 1861(n) of the *Social Security Act* and the cost of these features are the responsibility of the beneficiary. Suppliers of SGDs are encouraged to furnish the beneficiary with a voluntary Advance Beneficiary Notice (ABN) which informs that these features are not covered by Medicare and the beneficiary is liable for the expense of these features.

Other

MACs acting within their respective jurisdictions have discretion to cover or not cover speech generating devices based on their individual reasonable and necessary determinations.

Additional Information

The official instruction, CR9281, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R184NCD.pdf> on the CMS website. The revised portion of the *NCD Manual* is part of CR9281.

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

Fee Schedule Updates (GEN)

The 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:

- 3rd Quarter 2015 Jurisdiction A DME MAC Fee Schedule
- 3rd Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2015 Oral Anticancer Drug Fees

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 Mews Flash (GEN)

New products from the Medicare Learning Network® (MLN)

- *HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules*
Fact Sheet, ICN 909001, downloadable
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909001.html>
- *The DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet*
Fact Sheet, ICN 905283, downloadable
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Repair_Replacement_Factsheet_ICN905283.pdf
- *Home Oxygen Therapy*
Booklet, (ICN 908804), downloadable
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908804.html>
- *Medicare Quarterly Provider Compliance Newsletter* [Volume 5, Issue 4]
Educational Tool, ICN 909220, downloadable
<http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909220.html>

General Information

Revised products from the Medicare Learning Network® (MLN)

- *ICD-10-CM/PCS Billing and Payment Frequently Asked Questions*
Fact Sheet (ICN 908974)
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD-10BillingandPaymentFAQs.pdf>
- *The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation*
Fact Sheet, ICN 905710, Downloadable only
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246764.html>
- *Preventive Services*
Educational Tool, ICN 006559, interactive download
http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- *PECOS Technical Assistance Contact Information*
Fact Sheet, ICN 903766, downloadable
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243418.html>
- *837P and Form CMS-1500*
Web-Based Training (WBT) has been revised and is now available
<http://learner.mlnlms.com/Catalog/TrainingCatalog.aspx?at=T>

Subscribe to the 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.

Prepare for ICD-10 with MLN Connects® Videos

Prepare for the transition to ICD-10 on October 1, 2015. MLN Connects® videos are available on coding basics, testing, home health, and more:

- ICD-10 Coding Basics (<https://www.youtube.com/watch?v=kCV6aFIA-Sc&feature=youtu.be>)
- Coding for ICD-10-CM: More of the Basics
(<https://www.youtube.com/watch?v=s86pXhhOG7c&list=UUhHTRPxz8awulGaTMh3SAkA>)
- Estimating the Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments
(<https://www.youtube.com/watch?v=dZxilyTjfgI>)
- Medicare's Testing Plan for ICD-10 Success (<https://www.youtube.com/watch?v=QJeHxPYirjA>)
- Converting the Home Health Prospective Payment System Grouper to ICD-10-CM
(https://www.youtube.com/watch?v=NpG_6ijF00k&feature=youtu.be)
- ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project
(<http://www.youtube.com/watch?v=WLGofe1nPao&feature=youtu.be>)

Browse the MLN Connects® - Call Program Collection of Resources

The CMS MLN Connects® National Provider Call Program has hosted many educational conference calls for the health care community on a variety of topics, including ICD-10, PQRS, Chronic Care Management, Open Payments (the *Sunshine Act*), 2-Midnight Rule, Medicare Shared Savings Program, ESRD QIP, and Dementia Care in Nursing Homes - just to name a few. Check out our Calls and Events (<http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html>) web page for links to slide presentations, audio recordings, written transcripts, and a list of upcoming calls, or view one of our videos (<https://www.youtube.com/playlist?list=PLaV7m2-zFKpihHxb4AiWNjbsIUUKCGIjK>) on the Medicare Learning Network® Playlist on the CMS YouTube Channel. Become more informed about the Medicare program by reading, listening, or viewing these information-packed programs at your convenience. Visit <http://www.cms.gov/npc> for more information on the MLN Connects® National Provider Call Program.

MLN Connects® Provider eNews (GEN)

MLN Connects® Provider eNews for June 11, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-11-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-06-11-eNews.pdf>

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care and QAPI - Last Chance to Register
- Hospice Quality and Hospice Item Set Manual V1.02 - Last Chance to Register
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Last Chance to Register
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data - Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 - Register Now

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Updated Results for ICD-10 End-to-End Testing Week in April
- Recognizing Men's Health Month and Men's Health Week
- CMS Finalizes Rules for Medicare Shared Savings Program
- Comprehensive Prevention Program Effectively Reduces Falls among Older People
- EHR Incentive Programs: Comments on Meaningful Use Proposed Rule Due June 15
- 2015 PQRS GPRO: 2 Weeks Left to Register by June 30 Deadline
- EHR Incentive Program: Deadline for Eligible Professionals Hardship Exception is July 1
- ICD-10 Resources for Medicare Providers

Claims, Pricers, and Codes

- 2016 ICD-10-CM Files, ICD-10-PCS Files, and GEMs Available
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Information and Resources for Submitting Correct ICD-10 Codes to Medicare" MLN Matters® Article - Released
- "Transcatheter Aortic Valve Replacement (TAVR) Hospital Program Volume Requirements" MLN Matters® Special Edition Article - Released
- "Revised and Clarified Place of Service (POS) Coding Instructions" Podcast - Released
- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article - Revised
- "Skilled Nursing Facility (SNF) Billing Reference" Fact Sheet - Reminder
- Medicare Learning Network Product® Available In Electronic Publication Format
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

General Information

MLN Connects® Provider eNews for June 18, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-18-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-06-18-eNews.pdf>

MLN Connects® National Provider Calls

- ESRD QIP System Training - Save the Date
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data - Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs - Registration Now Open
- ESRD QIP: Proposed Rule for Payment Year 2019 - Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Medicare Provides Coverage of HIV Screening
- Medicare and Medicaid 50th Anniversary Count Down
- Use New Interactive Case Studies to Explore ICD-10 Concepts
- Corrections to eCQM Measures for 2016 Reporting
- 2015 PQRS GPRO: 1 Week Left to Register by June 30 Deadline

Claims, Pricers, and Codes

- CY 2015 Home Health PPS Mainframe Pricer Software Available

Medicare Learning Network® Educational Products

- "Using the ICD-10-PCS New Technology Section X Codes" MLN Matters® Article - Released
- "Reminder to Billing Procedures Related to the Department of Veterans Affairs (VA) - Companion Information to CR8198" MLN Matters® Article - Released
- "FAQs - International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article - Revised
- "General Equivalence Mappings Frequently Asked Questions" Booklet - Revised
- "ICD-10-CM/PCS Myths and Facts" Fact Sheet - Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet - Revised
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet - Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® Provider eNews for June 25, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-06-25-enews.pdf>

Editor's Note:

The October 1, 2015, compliance date for ICD-10 will be here in less than 100 days. Starting this week, your eNews has a new "Countdown to ICD-10" section, which groups all related information in one place to help you prepare.

Countdown to ICD-10

- ICD-10 Deadline: October 1, 2015
- ICD-10 Training Series for Small and Rural Practices
- Claims that Span the ICD-10 Implementation Date
- ICD-10 FAQs: CMNs, Prescriptions, and Orders
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health

MLN Connects® National Provider Calls

- ESRD QIP System Training - Registration Now Open
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data - Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs - Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 - Register Now

MLN Connects® Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool - Webcast

Announcements

- Are You Providing an Annual Wellness Visit to Your Medicare Patients?
- *Affordable Care Act* Payment Model Saves More than \$25 Million in First Performance Year
- National Medicare Fraud Takedown Results in Charges against 243 Individuals for Approximately \$712 Million in False Billing
- Changes to the Medicare Opt-Out Law for Physicians and Practitioners
- Corrections to eCQM Measures for 2016 Reporting

Claims, Pricers, and Codes

- July 2015 Outpatient Prospective Payment System Pricer File Update
- CY 2015 Home Health PPS Mainframe Pricer Software Available

Medicare Learning Network® Educational Products

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

General Information

MLN Connects® Provider eNews for July 02, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-07-02-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-07-02-eNews.pdf>

Countdown to ICD-10

- Results From June 2015 ICD-10 Acknowledgement Testing Week
- “ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” Fact Sheet - Revised
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls

- ESRD QIP System Training - Last Chance to Register
- ESRD QIP: Reviewing Your Facility’s PY 2016 Performance Data - Last Chance to Register
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs - Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 - Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

MLN Connects® Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool - Webcast

Announcements

- Open Payments Posts Full Year of 2014 Financial Data
- Proposed CY 2016 Updates to Policies and Payment Rates for ESRD Facilities
- ACO Investment Model
- DMEPOS Competitive Bidding: Common Ownership and Control
- Physician-Owned Hospital Ownership Reporting: Release of the CMS 855POH
- AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture
- EHR Incentive Program: Discontinuation of EHR-Randomizer Application Effective July 1
- PV-PQRS: Transition from IACS to EIDM-Act by July 2

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set

Medicare Learning Network® Educational Products

- “Medicare Costs at a Glance: 2015” Fact Sheet - Released
- “Provider Compliance Tips for Computed Tomography (CT Scans)” Fact Sheet - Revised
- “Medicare Remit Easy Print Software” Fact Sheet - Revised
- “Mass Immunizers and Roster Billing” Fact Sheet - Revised
- “Medicare Preventive Services” Educational Tool - Reminder
- “Medicare Basics Commonly Used Acronyms” Educational Tool - Reminder
- Medicare Learning Network Product Available In Electronic Publication Format
- Upgraded Learning Management System - Coming Soon

MLN Connects® Provider eNews for July 09, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-07-09-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-07-09-eNews.pdf>

Countdown to ICD-10

- CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10
- MLN Connects National Provider Call: Countdown to ICD-10
- “ICD-10 Website Wheel” Educational Tool - Released
- “Medicare FFS Claims Processing Guidance for Implementing ICD-10 - A Re-Issue of MM7492” MLN Matters® Article - Revised
- Medicare Learning Network ICD-10 Products Available In Electronic Publication Format
- Get Ready for ICD-10 with the CMS Infographic
- ICD-10 Resources for Medicare Providers

MLN Connects® National Provider Calls and Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool Webcast - Last Chance to Register
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs Call - Last Chance to Register
- ESRD QIP: Proposed Rule for Payment Year 2019 Call - Register Now
- Check Out the MLN Connects Call Program Collection of Provider Resources

CMS Events

- PERM Cycle 1 Provider Education Sessions

Announcements

- Proposed Hospital Outpatient and ASC Policy and Payment Changes for 2016, including Two-Midnight Rule
- New Initiative to Promote Value-Based Home Health Care
- PV-PQRS Users: Do Not Log into the Portal until Further Notice
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- EHR Incentive Programs: Reporting CQMs with a Zero Numerator and/or Denominator

General Information

MLN Connects® Provider eNews for July 16, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-07-16-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-07-16-eNews.pdf>

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10
- Claims that Span the ICD-10 Implementation Date

MLN Connects® National Provider Calls and Events

- ESRD QIP: Proposed Rule for Payment Year 2019 Call - Register Now
- Hospital Compare Overall Star Ratings Methodology Call - Registration Now Open

CMS Events

- PERM Cycle 1 Provider Education Session

Announcements

- World Hepatitis Day - Medicare Coverage for Viral Hepatitis
- CMS Cutting-Edge Technology Identifies and Prevents \$820 Million in Improper Medicare Payments in First Three Years
- Comprehensive Care for Joint Replacement
- PV-PQRS Users: Set up Your EIDM Account
- Home Health Agencies to Receive PEPPER
- CMS to Release a Comparative Billing Report on CT of the Abdomen and Pelvis in August
- eCQM: 2015 QRDA Implementation Guide Addendum Available
- Quarterly Provider Update for July 2015

Medicare Learning Network® Educational Products

- Medicare Learning Network Products Available in Electronic Publication Format
- Upgraded Learning Management and Product Ordering System - Important Updates

MLN Connects® Provider eNews for July 23, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-07-23-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-07-23-eNews.pdf>

Countdown to ICD-10

- ICD-10 Is Less than 70 Days Away: Get Ready
- Are Non-HIPPA Covered Entities Required to Transition to ICD-10?
- MLN Connects National Provider Call: Countdown to ICD-10
- Video: 10 Facts about ICD-10

MLN Connects® National Provider Calls and Events

- ESRD QIP: Proposed Rule for Payment Year 2019 Call - Last Chance to Register
- Proposed Reform of Requirements for Long-Term Care Facilities Call - Registration Now Open
- Hospital Compare Overall Star Ratings Methodology Call - Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts
- Associations and Organizations Providing Credit for MLN Connects Events

Announcements

- CMS Releases First Round of Home Health Compare Quality of Patient Care Star Ratings
- CMS Announces Medicare Care Choices Model Awards
- LTCH QRP Data Submission Deadline: August 15
- IRF QRP Data Submission Deadline: August 15
- Updated Open Payments CME Guidance
- eCQM: 2016 QRDA Implementation Guide Now Available

Claims, Pricers, and Codes

- July 2015 OPPTS Pricer File Update

Medicare Learning Network® Educational Products

- “Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 4]” Educational Tool - Released
- “Home Oxygen Therapy” Booklet - Released
- “The Basics of DMEPOS Accreditation” Fact Sheet - Revised
- “Medical Privacy of Protected Health Information” Fact Sheet - Reminder
- “Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians” Web-Based Training Course - Reminder
- Medicare Learning Network Products Available In Electronic Publication Format
- New Continuing Education Organization Now Accepting Medicare Learning Network Web-Based Training Courses

General Information

MLN Connects® Provider eNews for July 30, 2015

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-07-30-eNews.html>

View this edition as a PDF

<http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-07-30-eNews.pdf>

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
- MLN Connects National Provider Call: Countdown to ICD-10
- List of Valid ICD-10-CM Codes
- Use of Unspecified Codes in ICD-10-CM
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health
- Claims that Span the ICD-10 Implementation Date

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call - Register Now
- Hospital Compare Overall Star Ratings Methodology Call - Register Now
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- On Its 50th Anniversary, More than 55 Million Americans Covered by Medicare
- Temporary Moratoria Extended on Enrollment of Home Health Agencies and Ambulance Suppliers
- eCQM: Version 2 Schematron Rules for 2016 QRDA Implementation Guide Now Available

Medicare Learning Network® Educational Products

- July 2015 Version of the Medicare Learning Network Catalog - Released
- "Medicare Claim Review Programs" Booklet - Revised
- Medicare Learning Network Products Available in Electronic Publication Format
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for August 06, 2015

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-08-06-eNews.html>

View this edition as a PDF

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-08-06-eNews.pdf>

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities - Update
- MLN Connects National Provider Call: Countdown to ICD-10
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call - Last Chance to Register
- Hospital Compare Overall Star Ratings Methodology Call - Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call - Registration Now Open
- New MLN Connects National Provider Event Audio Recording and Transcript

MLN Connects Videos

- New Videos on HIS Manual for Hospice Quality Reporting Program

Announcements

- Inpatient and Long-term Care Hospital PPS: Final FY 2016 Payment and Policy Changes
- Skilled Nursing Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Rehabilitation Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2016 Payment and Policy Changes
- Hospice: Final FY 2016 Payment Rates
- Immunizations - Not Just for Kids
- Technical Correction to ESRD PPS Proposed Rule
- Decision Memorandum and Revised Scope of Benefit NCD for Speech Generating Devices
- Hospice Providers: Review HIS Reports to Confirm Successful Submission
- PEPPERS Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs, and PHPs
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: Determine Broadband Speed in Your Area

Claims, Pricers, and Codes

- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System - Going Live August 12
- "HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules" Fact Sheet - Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article - Revised
- Medicare Learning Network Products Available in Electronic Publication Format

General Information

MLN Connects® Provider eNews for August 13, 2015

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-08-13-eNews.html>

View this edition as a PDF

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-08-13-eNews.pdf>

Editor's Note:

Your responses to our eNews feedback tool help us improve our service. Each week, we offer an online version of the eNews, as well as a PDF version, located below the table of contents on the web page. If you are having trouble viewing the eNews, please let us know through our updated feedback tool. If you have a question about Medicare, please contact your Medicare Administrative Contractor.

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10
- Finding ICD-10 Information Online Just Got Easier
- 5 Ways to Check Your Claim Status
- Home Health Episodes that Span October 1, 2015
- New CMS Infographic: Get the Facts About ICD-10

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call - Register Now
- New MLN Connects National Provider Event Audio Recording and Transcript

Announcements

- DMEPOS Competitive Bidding: Timeline for Round 1 2017

Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System - Now Live

MLN Connects® Provider eNews for August 20, 2015

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-08-20-eNews.html>

View this edition as a PDF

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-08-20-eNews.pdf>

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10 - Last Chance to Register
- Use of Unspecified Codes in ICD-10-CM
- List of Valid ICD-10-CM Codes
- ICD-10 Clinical Concepts Guides for Specialties

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call - Register Now
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast - Register Now

CMS Events

- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis for Referring Providers
- Hospital Quality Reporting Program Webinars: Impact of FY 2016 Payment Rule
- Hospital Quality Reporting Webinar Series: Early Management Bundle, Severe Sepsis/Septic Shock

Announcements

- Additional Participants in Pilot Project to Improve Care and Reduce Costs for Medicare
- CMS Implements Changes in its Medical Review Education and Enforcement Strategies
- ESRD QIP PY 2016 Preview Period Extended
- Get Ready for DMEPOS Competitive Bidding

Claims, Pricers, and Codes

- Claims Hold for Diabetic Test Strips and Other Supply Items

Medicare Learning Network® Educational Products

- “National Site Visit Verification (NSV) Initiative” MLN Matters Article - Released
- “Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims” MLN Matters Article - Released
- “PECOS Technical Assistance Contact Information” Fact Sheet - Revised

General Information

MLN Connects® Provider eNews for August 27, 2015

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-08-27-eNews.html>

View this edition as a PDF

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-08-27-eNews.pdf>

Countdown to ICD-10

- Get ICD-10 Answers in One Place
- ICD-10 Resources
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Claims that Span the ICD-10 Implementation Date
- ICD-10-CM POA Exempt Codes for FY 2016 Available
- MS-DRG Grouper and MCE Software Available
- Video Slideshow from June 18 MLN Connects ICD-10 Call Available

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call - Last Chance to Register
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast - Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call - Registration Now Open
- New MLN Connects National Provider Call Audio Recordings and Transcripts

Other CMS Events

- PQRS Webinars: Public Reporting of 2014 Measures

Announcements

- Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings
- Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding

Medicare Learning Network® Educational Products

- “Medicare Enrollment for Physicians and Other Part B Suppliers” Fact Sheet - Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for September 03, 2015

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-09-03-eNews.html>

View this edition as a PDF

<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-09-03-eNews.pdf>

Countdown to ICD-10

- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- “General Equivalence Mappings Frequently Asked Questions” Booklet - Revised
- “ICD-10-CM/PCS ICD-10-CM/PCS Myths and Facts” Fact Sheet - Revised
- “ICD-10-CM Classification Enhancements” Fact Sheet - Revised
- “ICD-10-CM/PCS The Next Generation of Coding” Fact Sheet - Revised
- Get Ready Now: Assess How ICD-10 Will Affect Your Practice
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls and Events

- Overview of the 2014 Annual Quality and Resource Use Reports Webcast - Register Now
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call - Registration Now Open
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call - Register Now

Announcements

- CMS to Extend Initiative to Improve Care for Nursing Facility Residents
- DMEPOS Competitive Bidding Program: Prepare for Round 1 2017
- New ST PEPPER Available
- EHR Incentive Programs: Determine Broadband Speed in Your Area

Claims, Pricers, and Codes

- October 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- “837P and Form CMS-1500” Web-Based Training Course - Revised

DME MAC Jurisdiction A Local Coverage Determinations (LCDs)

The LCDs can be found on the DME MAC A Web site at:

<http://www.medicarenhic.com/dme/mrlcdcurren.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>

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

This article was originally published in January 2015 and is revised to reflect that external infusion pumps do not require a recertification DIF when the length of need expires and the ordering physician extends the length of need. A revised DIF is the proper form for the supplier to complete.

The DME MACs use DME Information Forms (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

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 table below).

Revised DIF:

A Revised DIF is 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:

Category	Reason
External Infusion	Changes in the existing drug HCPCS code
	Substitution of drug HCPCS code for existing drug HCPCS code
	Addition of drug HCPCS code
	Change in the route of administration
	Change in method of administration
	Extend expired length of need

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

Recertification DIF:

A Recertification DIF is required for parenteral and enteral pump (only) 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.

Draft Policies Released for Comment (GEN)

The Centers for Medicare and Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS). The DME MACs are proposing two revised LCDs and one new LCD. These LCDs require a 45-day public comment period. **The comment period for these LCDs begins on Thursday, July 16, 2015 and ends at Close of Business (COB) on Monday, August 31, 2015.**

The summaries below highlight only the major points in each LCD. Each draft LCD should be completely reviewed prior to the preparation of comments.

Bowel Management Devices (new LCD)

- Provides information necessary for processing claims for these technologies based upon their benefit category coverage status.

External Infusion Pumps (revision to existing LCD)

- Revises the criteria for reimbursement of intravenous inotropic medication

Lower Limb Prostheses (revision to existing LCD)

- Revises coverage for the provision of definitive prosthetic components in lieu of an immediate or preparatory prosthesis
- Implements a requirement for an independent medical exam to determine functional status
- Implements a requirement for a new amputee to participate in a rehabilitation program prior to the provision of a definitive prosthesis.
- Revises functional level modifiers (K-level modifiers)
- Revises codes for prosthetic feet

We are soliciting comments on these draft policies from physicians, manufacturers, suppliers and other professionals involved in the ordering of provision of these items. **For the External Infusion Pump policy, we are only soliciting comments regarding the revised criteria for the reimbursement of intravenous inotropic medications.**

We recommend that you distribute these draft policies to selected members of your organization for review and comment. If you disagree with any aspect of a policy, you should be very specific in your comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy.

Medical Review

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

All comments will be collected at a single point of contact. Please submit your comments electronically to the DME MAC medical director at the e-mail address below no later than Close of Business (COB) on the date indicated above for close of the comment period for the applicable LCD.

Stacey V. Brennan, M.D., FAAFP
Medical Director, DME MAC, Jurisdiction B
National Government Services
8115 Knue Rd
Indianapolis, IN 46250-1936
[DMAC Draft LCD Comments@anthem.com](mailto:DMAC_Draft_LCD_Comments@anthem.com)

The comment process requires a public meeting. A joint DME MAC public meeting will be held on **August 26, 2015, from 08:00 AM EDT until 12:00 PM EDT** at:

Airport Square Business Park
1304 Concourse Drive
Linthicum, MD 21090

Interested parties from any DME MAC jurisdiction may attend this public meeting. **This meeting provides the opportunity for brief oral presentations only.** There is no Question and Answer or discussion period as a part of the meeting. In order for oral presentation comments to be considered, they must be presented through the formal comment process.

Advance registration is required for attendance at the public meeting and the registrant must indicate whether participating as a presenter or attendee (listen only). Registration is online at:

http://apps.ngsmedicare.com/ADC/EventList.aspx?fromdate=8/1/2015&todate=8/31/2015&display=Month&type=public&eventidn=3031&view=EventDetails&information_id=5739

This registration must be completed no later than **COB Friday, August 21, 2015**. Registrants must include their name, contact information, organization, whether attending in person or via teleconference and the policy(s) upon which oral presentations will be made in their registration information.

The amount of time allotted to presentations is based upon the number of registered speakers. There shall be one presentation per company or organization. The DME MAC medical directors reserve the right to limit speakers and time as appropriate. Speakers should be prepared to adjust the length of their presentation depending upon the number of speakers.

IMPORTANT REMINDER Suppliers/providers are cautioned not to make any changes to business practices based upon the information contained in these draft documents. Drafts are often substantially revised based upon the comments received. When all comments have been reviewed, revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on individual DME MAC websites, allowing for adequate notice before the policies' effective date.

Refer to each DME MAC web site for additional information about policy development and copies of the draft LCDs.

Jurisdiction A	-	http://www.medicarenhic.com
Jurisdiction B	-	http://www.ngsmedicare.com
Jurisdiction C	-	http://www.cgsmedicare.com/jc
Jurisdiction D	-	http://med.noridianmedicare.com/web/jddme

Thank you for your participation in our policy revision process.

Sincerely,
Stacey V. Brennan, M.D., FAAFP

On behalf of:

Wilfred Mamuya, MD, PhD
Medical Director, DME MAC, Jurisdiction A
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043-1518
Wilfred.mamuya@hp.com

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C
CGS Administrators, LLC
2 Vantage Way
Nashville, TN 37228-1504
Robert.hoover@cgsadmin.com

Stacey V. Brennan, M.D., FAAFP
Medical Director, DME MAC, Jurisdiction B
National Government Services
8115 Knue Rd.
Indianapolis, IN 46250-1936
Stacey.brennan@anthem.com

Eileen M. Moynihan, MD, FACP, FACP
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions
900 42nd Street South
Fargo, ND 58103-2146
Eileen.moynihan@noridian.com

Surgical Dressings - Draft Policy Released for Comment (SPE)

Dear Supplier, Physician, Manufacturer, or other Interested Party,

The Centers for Medicare and Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS). The DME MACs are proposing to revise the Surgical Dressings LCD and related Policy Article. LCD medical necessity criteria require a 45-day public comment period. The related Policy Article does not require comment but is included as a courtesy. **The comment period for this LCD begins on Thursday, August 6, 2015 and ends at Close of Business (COB) on Monday, September 21, 2015.**

The summary below highlights only the major points the revised LCD. The draft LCD should be completely reviewed prior to the preparation of comments.

Surgical Dressings LCD

- Added a section for collagen dressings
- Added a section for zinc-paste impregnated gauze
- Added a section for dressings comprised of materials not recognized as effective
- Revised requirements for incompatible dressing materials
- Revised requirements for incompatible dressing change intervals
- Revised utilization (change interval) requirements

Related Policy Article

- Expanded discussion of statutory benefit requirements for a qualifying wound
- Expanded discussion of statutory benefit requirements defining a qualifying surgical dressing
- Consolidated a list of product types that are not classified as surgical dressings under the benefit
- Revised coding guidelines for dressing composed of multiple materials

We are soliciting comments on this draft policy from physicians, manufacturers, suppliers and other professionals involved in the ordering or provision of these items.

We recommend that you distribute this draft to selected members of your organization for review and comment. If you disagree with any aspect of a policy, you should be very specific in your comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy.

Medical Review

All comments will be collected at a single point of contact. Please submit your comments electronically to the DME MAC medical director at the e-mail address below no later than Close of Business (COB) on the date indicated above for close of the comment period for the applicable LCD.

Eileen Moynihan, MD
Noridian, LLC
Jurisdiction D DME Medical Review
PO Box 6742
Fargo, ND 58108-6742
policydmedraft@noridian.com

The comment process requires a public meeting. **A joint DME MAC public meeting will be held on August 26, 2015, from 08:00 AM EDT until 12:00 PM EDT at:**

Airport Square Business Park
1304 Concourse Drive
Linthicum, MD 21090

Interested parties from any DME MAC jurisdiction may attend this public meeting. This meeting provides the opportunity for brief oral presentations only. There is no Question and Answer or discussion period as a part of the meeting. In order for oral presentation comments to be considered, they must be presented in writing through the formal comment process.

Advance registration is required for attendance at the public meeting. The registrant must indicate whether participating as a presenter or attendee (listen only). Register online at:

http://apps.ngsmedicare.com/ADC/EventList.aspx?fromdate=8/1/2015&todate=8/31/2015&display=Month&type=public&eventidn=3031&view=EventDetails&information_id=5739

This registration must be completed no later than COB Friday, August 21, 2015. Registrants must include their name, contact information, organization, whether attending in person or via teleconference, and the policy(s) upon which oral presentations will be made in their registration information.

The amount of time allotted to presentations is based upon the number of registered speakers. There shall be one presentation per company or organization. The DME MAC medical directors reserve the right to limit speakers and time as appropriate. Speakers should be prepared to adjust the length of their presentation depending upon the number of speakers.

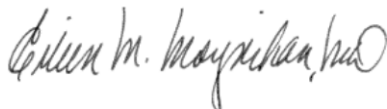
IMPORTANT REMINDER Suppliers/providers are cautioned not to make any changes to business practices based upon the information contained in these draft documents. Drafts are often substantially revised based upon the comments received. When all comments have been reviewed, revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on individual DME MAC websites, allowing for adequate notice before the policies' effective date.

Refer to each DME MAC web site for additional information about policy development and copies of the draft LCDs.

Jurisdiction A - <http://www.medicarenhic.com>
Jurisdiction B - <http://www.ngsmedicare.com>
Jurisdiction C - <http://www.cgsmedicare.com/jc>
Jurisdiction D - <http://med.noridianmedicare.com/web/jddme>

Thank you for your participation in our policy revision process.

Sincerely,
Eileen M. Moynihan, MD, FACP, FACR



On behalf of:

Wilfred Mamuya, MD, PhD
Medical Director, DME MAC, Jurisdiction A
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043-1518
Wilfred.mamuya@hp.com

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C
CGS Administrators, LLC
2 Vantage Way
Nashville, TN 37228-1504
Robert.hoover@cgsadmin.com

Stacey V. Brennan, M.D., FAAFP
Medical Director, DME MAC, Jurisdiction B
National Government Services
8115 Knue Rd.
Indianapolis, IN 46250-1936
Stacey.brennan@anthem.com

Eileen M. Moynihan, MD, FACP, FACR
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions
900 42nd Street South
Fargo, ND 58103-2146
Eileen.moynihan@noridian.com

Lower Limb Prosthesis Draft (July 2015) - Bibliography - Joint DME MAC Publication (O&P)

The DME MACs released a draft revision of the Lower Limb Prosthesis LCD for comment on July 16, 2015. The comment period runs through August 31, 2015. The policy template provides an optional field to list the references used in the preparation of a policy revision. As a general courtesy, the DME MACs provide a bibliography when policies are released for comment. The bibliography for this draft was inadvertently omitted during the publication process. The bibliography is provided below. We regret any inconvenience.

1. Alonso-Zalvidar R. Medicare puzzle: Big rise in artificial feet costs. AP Mobile News. February 16, 2012.
2. American Academy of Orthopaedic Surgeons. Atlas of Limb Prosthetics: Surgical, Prosthetic, and Rehabilitation Principles. Vol 2nd ed. St. Louis: Mosby Year Book; 1992.
3. AOPA. *Medicare Orthotic & Prosthetic Improvements Act* In the Senate - S.2125 In the House - H.R.1958. Vol 1395m(h)(1).; 2012.
4. Bakalim G. Experiences with the total-contact prosthesis. Artificial limbs. 1966;11(1):51-57.
5. Bowker JH. 29. Critical Choices: The Art of Prosthesis Prescription. In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.
6. CMS. *Medicare Benefit Policy Manual* Chapter 15 - Covered Medical and Other Health Services. 2003.
7. CMS. *Medicare Claims Processing Manual* Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). 2005.
8. Dave Thompson. Outcomes of Prosthetic Rehabilitation Can We Tell Who Is a Candidate for Prosthetic Rehabilitation? 2001. <http://moon.ouhsc.edu/dthompsogait/pobmk/amrehab1.htm> Accessed July 30, 2015.
9. DME MAC J-A. Widespread Prepayment Probe for Lower Limb Prostheses. May 2011.
10. DME MAC J-A. Results of Widespread Prepayment Probe for Lower Limb Prostheses. November 2011.
11. Ferguson J. Prosthetic feet. Orthotics and prosthetics in rehabilitation 2nd ed St Louis, MO: Saunders Elsevier. 2007:643-657.
12. Gailey RS, Clark CR. 23. Physical Therapy Management of Adult Lower-Limb Amputees. In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.

13. Gailey RS, Roach KE, Applegate EB, et al. The Amputee Mobility Predictor: An instrument to assess determinants of the lower-limb amputee's ability to ambulate. *Archives of Physical Medicine and Rehabilitation*. 2002;83(5):613-627. doi:10.1053/apmr.2002.32309.
14. Gailey RS. Predictive outcome measures versus functional outcome measures in the lower limb amputee. *JPO: Journal of Prosthetics and Orthotics*. 2006;18(6):P51-P60.
15. GAO. MEDICARE PROGRAM INTEGRITY Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment; 2012.
16. Gard SA, Konz RJ. The effect of a shock-absorbing pylon on the gait of persons with unilateral transtibial amputation. *Journal of rehabilitation research and development*. 2003;40(2):109-124.
17. Greene MP. Four bar linkage knee analysis. *Orthot Prosthet*. 1983;37(1):15-24.
18. Highsmith MJ. Prosthetic Feet: Classification and Overview. 2011.
19. Highsmith MJ. Prosthetic Knees: Classification and Overview. 2011.
20. Kapp S, Cummings D. 18B. Outcomes of Prosthetic Rehabilitation Can We Tell Who Is a Candidate for Prosthetic Rehabilitation? In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. *Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles*. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.
21. Kapp S, Miller JA, Pasquina PF, Cooper RA. Lower limb prosthetics. Pasquina PF, Cooper RA *Care of the combat amputee* Washington, DC: Borden Institute. 2009:553-580.
22. Kelly B. Lower Limb Prosthetics Introduction and Definitions. Medscape Reference. 2011.
23. Levinson DR, General I. Questionable billing by suppliers of lower limb prostheses. Health and Human Services HHS, Washington, DC. 2011.
24. Mark Kraft, Julius Thiele. Functional features of different microprocessor controlled knees -a technological study. September 2013.
25. Pascual L. Functional Considerations for Prosthetic Candidacy. October 2010.
26. Paul E Leimkuehler. Outcome Measures in Lower Limb Prosthetics. http://www.oandp.org/olc/lessons/html/SSC_06/section_06.asp?frmCourseSectionId=07. Accessed March 27, 2013.
27. Pritham CH. 24C. Special Considerations: Emerging Trends in Lower-Limb Prosthetics: Research and Development. In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. *Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles*. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.
28. Schuch CM. 20B. Transfemoral Amputation: Prosthetic Management. In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. *Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles*. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.
29. Smith DG, Burgess EM, Zettl JH. 24A. Special Considerations: Fitting and Training the Bilateral LowerLimb Amputee. In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. *Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles*. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.
30. Thiele J, Westebbe B, Bellmann M, Kraft M. Designs and performance of microprocessor-controlled knee joints. *Biomedizinische Technik/Biomedical Engineering*. 2013;0(0):1-13. doi:10.1515/bmt-2013-0069.
31. Waarde T van der, Michael JW. 21B. Hip Disarticulation and Transpelvic Amputation: Prosthetic Management. In: Smith DG, Michael JW, Bowker JH, American Academy of Orthopaedic Surgeons, eds. *Atlas of Amputations and Limb Deficiencies: Surgical, Prosthetic, and Rehabilitation Principles*. Vol 3rd ed. Rosemont, IL: American Academy of Orthopaedic Surgeons; 2004.

Coverage and Correct Coding of HYQVIA (Immune Globulin Infusion (Human) 10%, with Recombinant Human Hyaluronidase) - Revised - Joint DME MAC Publication (DRU)

This is a revision to previous version published on December 18, 2014.

On September 12, 2014, HYQVIA (Baxter Healthcare) was approved by the FDA. HYQVIA is a subcutaneously administered immune globulin 10% (Human) with recombinant human hyaluronidase, and is indicated for the treatment of Primary Immunodeficiency (PI) in adults.

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

HYQVIA is administered using a programmable variable infusion pump (HCPCS code E0781), that is capable of infusing a patient's therapeutic dose at infusion rates of up to 300 mL/hr/site.

Coverage is available for claims with dates of service on or after September 12, 2014 when all of the following requirements have been met:

- The criteria for Subcutaneous Immune Globulin as specified in the External Infusion Pump LCD are met, and
- HYQVIA is administered subcutaneously through an E0781 pump that is pre-programmed, and
- The E0781 pump is delivered to the Medicare beneficiary in a "locked mode" i.e., the patient is unable to self-adjust the infusion rate.

The medical record must contain sufficient information to clearly demonstrate that the beneficiary meets all of the requirements specified above.

Administration of HYQVIA requires a gradual increase in the infusion rate at the beginning of each infusion. This infusion rate ramp-up is patient-specific and must be determined under medical supervision over the course of several infusions of HYQVIA. Once the infusion rate ramp-up specification(s) have been determined, they can be programmed into an appropriate E0781 pump. There is no coverage under the Durable Medical Equipment Benefit for equipment, drugs and infusions supplies used during these initial doses as they are considered as incident to the required professional supervision. Claims to the DME MAC for the pump, drugs and supplies administered in this scenario will be denied as wrong jurisdiction.

Claims for HYQVIA 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
- Manufacturer name
- Dosage Strength
- Manufacturer's Suggested retail price (MSRP)

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.

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](#).

Correct Coding - Modifiers - AU, AV, and AW - Joint DME MAC Publication (GEN)

HCPCS modifiers have been established for use when items are furnished in conjunction with various supplies listed in multiple DME MAC Local Coverage Determinations (LCD) and Related Policy Articles (PA). These modifiers are effective for dates of service (DOS) on or after January 1, 2003 and claims submitted without the appropriate modifiers are currently denied as non-covered. Effective for dates of service on or after August 1, 2015, claims submitted without the appropriate modifier will be rejected as missing information. The modifier narratives are:

- AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
- AV - Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
- AW - Item furnished in conjunction with a surgical dressing

These modifiers identify items that are eligible for reimbursement under multiple benefit or payment categories. At this time, the only codes with which these modifiers may be used are:

- A4217 - Sterile water/saline, 500 ml
- A4450 - Tape, non-waterproof, per 18 square inches
- A4452 - Tape, waterproof, per 18 square inches
- A5120 - Skin barrier, wipes or swabs, each
- A6531 - Gradient compression stocking, below knee, 30-40 MMHG, each
- A6532 - Gradient compression stocking, below knee, 40-50 MMHG, each
- A6545 - Gradient compression stocking, wrap, non-elastic, below knee, 30-50 MM HG, each

For example, tape used with a facial prosthesis must be billed using the AV modifier. Tape used with an ostomy pouch must be billed with the AU modifier. Tape used with a surgical dressing must be billed using the AW modifier. The use of specific modifiers is addressed in each LCD and related PA in which these modifiers are applicable. Suppliers should consult the appropriate LCD and related PA for additional coverage, coding and documentation requirements.

These modifiers must not be used with any other HCPCS codes. Use of these modifiers with other codes will result in the return or rejection of the claim line(s) for incorrect modifier use.

Claims for codes A4217, A4450, A4452, A5120, A6531, A6532 and A6545 submitted without an AU, AV or AW modifier (as applicable) with dates of service on or after August 1, 2015 will be rejected as missing information and must be resubmitted with the correct modifier applied.

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

*This is a correction to articles previously published April 30, 2015 and March 27, 2014.
This article is being republished to correct some typographical errors in
HCPCS codes narrative descriptors for L0627 and L0642.*

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

When providing these items suppliers must:

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

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

Off-the-shelf (OTS) orthotics are:

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

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

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

Custom fitted orthotics are:

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

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

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

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

Kits are:

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

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

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

Medical Review

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](#).

Classification Algorithm - Overview of Criteria

Determining Proper Coding of Prefabricated Orthotics

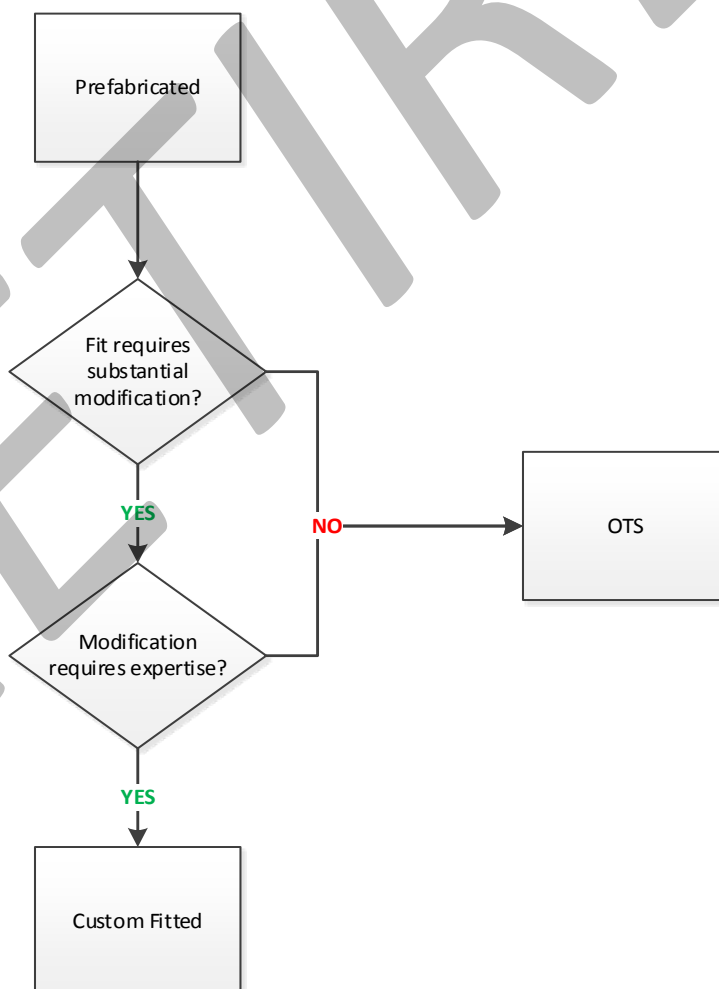
The following question and answer relates to whether a prefabricated orthotic is properly billed using a code for a custom fitted orthotic versus one furnished off-the-shelf and does not address medical necessity for the item. The descriptors for the HCPCS codes for custom fitted orthotics include the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

- Off-the-shelf (OTS) - Prefabricated item that requires minimal self-adjustment such as being trimmed, bent, molded, assembled, or otherwise adjusted to fit the beneficiary. Minimal self-adjustment does not require the expertise of a certified orthotist or an individual with equivalent expertise.
- Custom fitted - Prefabricated item that requires substantial modification e.g., has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by certified orthotist or an individual with equivalent expertise.

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

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

How to Decide What Code Type for Prefabricated Orthotic



2015 HCPCS New Code Table

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

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

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

Medical Review

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L0468	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0469	TLSO, SAGITTAL-CORONAL CONTROL, RIGID POSTERIOR FRAME AND FLEXIBLE SOFT ANTERIOR APRON WITH STRAPS, CLOSURES AND PADDING, EXTENDS FROM SACROCOCCYGEAL JUNCTION OVER SCAPULAE, LATERAL STRENGTH PROVIDED BY PELVIC, THORACIC, AND LATERAL FRAME PIECES, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, AND CORONAL PLANES, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISKS, PREFABRICATED, OFF-THE-SHELF
L0626	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0641	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0627	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0642	LUMBAR ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0630	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0643	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID POSTERIOR PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0631	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0648	LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L0633	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0649	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0637	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0650	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANELS, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0639	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L0651	LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, RIGID SHELL(S)/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, ANTERIOR EXTENDS FROM SYMPHYSIS PUBIS TO XYPHOID, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, OVERALL STRENGTH IS PROVIDED BY OVERLAPPING RIGID MATERIAL AND STABILIZING CLOSURES, INCLUDES STRAPS, CLOSURES, MAY INCLUDE SOFT INTERFACE, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L1600	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE		No Corresponding Code
L1610	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (FREJKA COVER ONLY), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE		No Corresponding Code
L1620	HIP ORTHOSIS, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, (PAVLIK HARNESS), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE		No Corresponding Code
L1810	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L1812	KNEE ORTHOSIS, ELASTIC WITH JOINTS, PREFABRICATED, OFF-THE-SHELF

Medical Review

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L1832	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L1833	KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, OFF-THE-SHELF
L1843	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	K0901	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF
L1845	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	K0902	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF
L1847	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L1848	KNEE ORTHOSIS, DOUBLE UPRIGHT WITH ADJUSTABLE JOINT, WITH INFLATABLE AIR SUPPORT CHAMBER(S), PREFABRICATED, OFF-THE-SHELF
L3677	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3678	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3807	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3809	WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED, OFF-THE-SHELF, ANY TYPE
L3915	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3916	WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF
L3917	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3918	HAND ORTHOSIS, METACARPAL FRACTURE ORTHOSIS, PREFABRICATED, OFF-THE-SHELF
L3923	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3924	HAND FINGER ORTHOSIS, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, OFF-THE-SHELF

HCPCS	Custom Fitted Codes	HCPCS	Off-the-Shelf Codes
L3929	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L3930	HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, PREFABRICATED, OFF-THE-SHELF
L4360	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L4361	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4386	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L4387	WALKING BOOT, NON-PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF
L4396	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE	L4397	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, OFF-THE-SHELF

Parenteral Nutrition CERT Errors - Documentation Reminder - Joint DME MAC Publication (PEN)

A recent examination of CERT reviews for parenteral nutrition 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

- Statutory Requirements
 - Statutory coverage requirements not met - 32%
- Prescriptions
 - Physician's detailed written order (DWO) not submitted with claim - 16%
 - Physician's DWO missing detailed item description - 11%
 - Physician's DWO not signed - 10%
 - Physician's DWO not dated - 4%
- DME Information Form (DIF)
 - Missing DIF - 16%
- Continued Need
 - Missing documentation - 2%
- Continued Use
 - Missing documentation - 4%
- Other
 - Unsigned Clinical Notes - 2%

Medical Review

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.

Documentation

In the event of a claim review:

- Medicare requires a Detailed Written Order (DWO).
- 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. The majority of reasons for CERT errors (59%) are completely within the purview of suppliers. Thus, suppliers are encouraged to review their claim submission practices, in order to reduce the high level of CERT errors. Statutory requirements necessary for coverage are not discussed in this article. Please refer to the Parenteral Nutrition LCD and related Policy article for complete information.

Further education regarding this policy is available on your DME MAC Contractor's web site.

PDAC Code Review - E0740 Non-Implantable Pelvic Floor Electrical Stimulator DME MAC Joint Publication (SPE)

The Pricing, Data, Analysis and Coding Contractor (PDAC) recently evaluated HCPCS code E0740 (INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONITOR, SENSOR AND/OR TRAINER) and discovered two differing product types on the Product List: (1) pelvic floor muscle electrical stimulators, and (2) pelvic floor muscle monitoring devices. The PDAC reviewed the history of the code to determine which product type E0740 was intended to describe.

Code E0740 History

During the 1980's E0740 was used to describe a battery used in a TENS device. In 1988 the code was discontinued. In 1995, the CMS HCPCS Workgroup reassigned the code as:

E0740 (INCONTINENCE TREATMENT SYSTEM, PELVIC FLOOR STIMULATOR, MONITOR, SENSOR AND/OR TRAINER).

This reassigned code narrative was effective for use January 1, 1995.

CMS concurrently published a National Coverage Determination (NCD 230.8) for pelvic floor electrical stimulators. The NCD says:

230.8 - Non-Implantable Pelvic Floor Electrical Stimulator

Non-implantable pelvic floor electrical stimulators provide neuromuscular electrical stimulation through the pelvic floor with the intent of strengthening and exercising pelvic floor musculature. Stimulation is generally delivered by vaginal or anal probes connected to an external pulse generator.

The methods of pelvic floor electrical stimulation vary in location, stimulus frequency (Hz), stimulus intensity or amplitude (mA), pulse duration (duty cycle), treatments per day, number of treatment days per week, length of time for each treatment session, overall time period for device use and between clinic and home settings. In general, the stimulus frequency and other parameters are chosen based on the patient's clinical diagnosis.

Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.

A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Part of the code history assessment is to identify what product were initially included in E0740 when the revised code narrative was assigned in 1995. CMS Alpha-Numeric Workgroup applications from 1995 were reviewed to determine the predicate product(s) used to establish HCPCS code E0740. A predicate product is the item(s) used as the index product in the establishment of the original HCPCS code and is the exemplar to which other products are compared when assessing code assignment. The three predicate products used for code E0740 in 1995 were:

- Perry Vaginal (Self-Regulation Systems, Inc.)
- Perry Anal (Self-Regulation Systems, Inc.)
- Innova™ Feminine Incontinence Treatment System (Empi, Inc.)

All of these products are non-implantable pelvic floor electrical stimulation devices with muscle contraction monitoring capability included.

Coding Determination

Based upon the code narrative, code history including the predicate products, and creation of National Coverage Determination 230.8, the PDAC concluded that HCPCS code E0740 is intended to describe non-implantable pelvic floor electrical stimulators with integrated monitoring capabilities. Devices limited to only muscle monitoring capability (i.e., without electrical muscle stimulation capability) were not intended to be included in E0740.

Product Review

Products that only have monitoring capabilities but do not include electrical stimulation of the pelvic floor muscles have been assigned to E0740. All products currently listed on the PDAC Product Classification List with HCPCS code E0740 will undergo a code review. Manufacturers of affected products will be notified to submit product information to the PDAC to take into consideration along with the product information already on file.

Coding for Monitoring Devices

In general, Medicare does not provide reimbursement for devices used to provide monitoring functions. There may be some Part B coverage for devices used as part of biofeedback therapy. Biofeedback therapy does not fall within DME contractor jurisdiction. Consult the appropriate A/B MAC for information regarding coverage and coding for devices used for biofeedback therapy. Coding for products that fall within DME contractor jurisdiction will be assigned as part of the coding review process.

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 email the PDAC by completing the [DME PDAC Contact Form](#).

Correct Coding - Surgical Dressings Containing Unclassified Materials - DME MAC Joint Publication (SPE)

Note: A previous version of this article was published in January 2015. The January publication was subsequently removed due to an inaccuracy in a reference to A9270. This article replaces that previous publication.

Some multi-component surgical dressings contain materials for which no specific HCPCS code exists. This article reviews the coding guidelines for these items.

Historically, materials not having specific HCPCS codes have not comprised the majority constituent(s) in multi-component products. Thus, these materials were not taken into consideration for HCPCS coding purposes. The longstanding coding guideline for multi-

Medical Review

component dressings states that the clinically predominant component will determine classification. The current Surgical Dressings Local Coverage Determination (LCD) related Policy Article (PA) Coding Guidelines says:

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.

Recently, multi-component dressings with non-classified (non-coded) components comprising the majority of the dressing's materials have been identified. The following clarification to the current guideline is being published in order to assure consistent interpretation of the "clinically predominant component" criterion. The revised coding guidelines clarify how products with non-coded materials are to be classified:

Multi-component dressings that are not classified as composite dressings are categorized according to the clinically predominant component. The clinically predominant component is defined based on the proportion of material(s) in the dressing. For example, a dressing that is 60 percent hydrocolloid and 40 percent alginates would be categorized as a hydrocolloid dressing. HCPCS coding is determined based on the following:

- Products where a single material comprises greater than 50% (by weight) of a product's composition are coded based upon the applicable specific HCPCS code for that material. If a specific HCPCS code does not exist for the predominant component, HCPCS code A4649 (Surgical Supply, miscellaneous) is used.
- Products where no single material comprises greater than 50% (by weight) of the composition are coded as A4649 (Surgical Supply, miscellaneous).

The Surgical Dressings LCD related Policy Article Coding Guideline section will be updated to include this information.

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

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/>

LCD and Policy Article Revisions Summary for June 11, 2015 - Revised (GEN)

This article was originally published on June 11, 2015 and is revised to reflect the removal of the future Surgical Dressings Local Coverage Determination and Policy Article.

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Facial Prosthesis, Ostomy Supplies, Tracheostomy Care Supplies and Urological Supplies. Please review each entire LCD and each related PA for complete information.

Facial Prosthesis

LCD

Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

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

DOCUMENTATION REQUIREMENTS:

Deleted: Reference to refill of supplies from Continued Use

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

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

(Note: Standard Documentation Language updates noted above are effective for DOS on or after 10/31/2014)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Language for HCPCS Codes A4450, A4452, A5120 when submitted without correct modifier

Policy Article

Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Language for HCPCS codes A4450, A4452, A5120 that are billed without correct modifier

Ostomy Supplies

LCD

Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

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

DOCUMENTATION REQUIREMENTS:

Removed: ICD-9 references

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

(Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Language for HCPCS codes A4450, A4452 and A5120 when submitted without correct modifier

Policy Article

Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: ICD-9 references

Revised: Language for HCPCS codes A4450, A4452, A5120 when submitted without correct modifier

Tracheostomy Care Supplies

LCD

Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

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

DOCUMENTATION REQUIREMENTS:

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

(Note: Standard Documentation Language updates noted above are effective for DOS on or after 10/31/2014)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Removed: ICD-9 references

Added: Language for HCPCS codes A4450, A4452, A5120 when submitted without correct modifier

Policy Article

Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Language for HCPCS codes A4450, A4452, A5120 when submitted without correct modifier

Urological Supplies

LCD

Revision Effective Date: 08/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

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

DOCUMENTATION REQUIREMENTS:

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

(Note: Standard Documentation Language updates noted above are effective for DOS on or after 10/31/2014)

Added: Language for HCPCS codes A4217, A4450, A4452 when submitted without correct modifier

Policy Article

Revision Effective Date: 08/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: KX modifier reference from this section

Revised: Language for HCPCS codes A4217, A4450, A4452 when submitted without correct modifier

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.

Medical Review

LCD and Policy Article Revisions Summary for June 25, 2015 (GEN)

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

Nebulizers

LCD

Revision Effective Date: 10/31/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

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

DOCUMENTATION REQUIREMENTS:

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

Added: Instructions for Equipment Retained from a Prior Payer

Revised: Repair to beneficiary-owned DMEPOS

MISCELLANEOUS:

Added: Instructions for HCPCS code Q9977 - Effective 07/01/2015

Policy Article

Revision Effective Date: 10/31/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Language for billing metered-dose inhalers not administered through DME

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

Revised: Face-to-Face Requirements for treating practitioner

CODING GUIDELINES:

Added: Instructions for code Q9977 - Effective 07/01/2015

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 July 23, 2015 (DRU)

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

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective date: 07/01/2015

HCPCS CODES:

Added: HCPCS code Q9978

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Q9978 to modifier billing instructions effective 07/01/2015

Policy Article

Revision Effective Date: 07/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Drug name Akynzeo®

Added: Q9978 for billing after 07/01/15

CODING GUIDELINES:

Removed: Drug name Akynzeo®

Added: Q9978 for billing after 07/01/15

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 August 20, 2015 (SPE)

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

Commodes

LCD

Revision Effective Date: 10/31/2014 (August 2015 Publication)

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Incorporated NCD 280.1 coverage statement regarding, bidets, bidet toilet seats and similar

Policy Article

Revision Effective Date: 04/01/2013 (August 2015 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Coverage statement for bidets and similar items

CODING GUIDELINES:

Added: Code description for bidets, bidet toilet seats and similar items

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.

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 45.7%. A summary of findings was published on the NHIC, Corp. Web site on April 23, 2015. Based on this result, a widespread prepayment review was continued.

Current Review Results

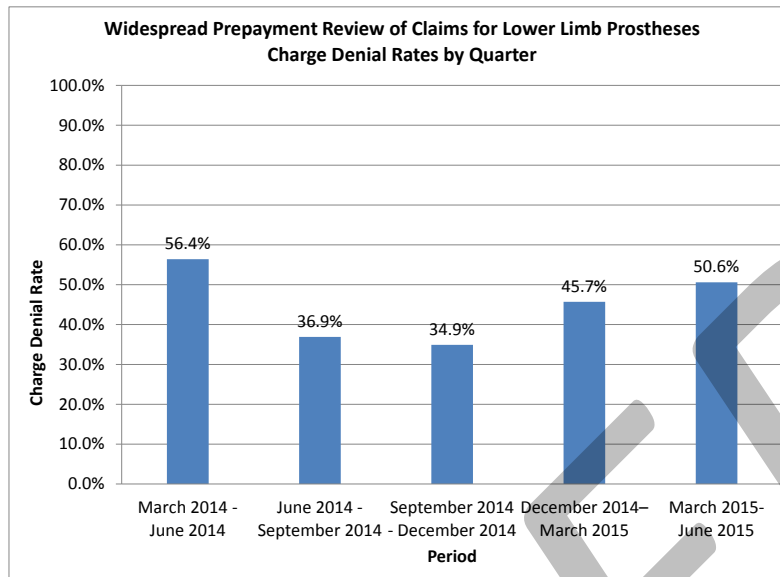
DME MAC Jurisdiction A has completed a widespread prepayment complex review of claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier.

The review involved prepayment complex medical review of 232 claims submitted by 139 suppliers for claims processed March 01, 2015 to June 01, 2015. Responses to the Additional Documentation Request (ADR) were not received for 39 (17%) of the claims. For the remaining 193 claims, 90 claims were allowed and 103 were denied resulting in a claim denial rate of 53%. The overall Charge Denial Rate was 50.6%.

Charge Denial Rate Historical Data

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

Medical Review



Reasons for Denial

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

Lack of Medical Record Documentation

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

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

- 12% of the denied claims had medical records submitted but the records did not justify the functional level of the billed item(s).

Proof of Delivery

- 7% of the denied claims were missing a valid Proof of Delivery. Proof of Delivery was missing items delivered; items must be sufficiently detailed to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)

Reason for Replacement

- 14% of the denied claims had no statement or reason for replacement either on the physician's order or in the medical documentation.

Claim Examples

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

Example 1:

Received: The supplier submitted a Detailed Written Order, which includes the beneficiary's name, specific items 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 2:

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

Delivery that includes the manufacturer, model numbers and cost of each item, verifying that the beneficiary received the items that were billed; The prosthetist's evaluation/assessment and clinical documentation detailing the functional level of the items billed; Clinical documentation to support functional level of the device and to corroborate the prosthetist's records.

Missing: Information by the ordering physician, either on the Detailed Written Order or in the medical record, demonstrating the reason for replacement.

Example 3:

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

Missing: Clinical documentation to support functional level of the device and to corroborate the prosthetist's records. Proof of Delivery was missing which verifies that the beneficiary received the items that were billed.

Next Step

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

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

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

NHIC offers a self-service tool, **Decision Desktop**, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: <http://www.medicarenhic.com/dme/mr.aspx>

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 \(A25310\)](#)
- [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
- [Dear Physician Letter](#) - Documentation of Artificial Limbs
- [CERT Error Articles](#)
- [Lower Limb Prostheses Documentation Reminder for Physicians](#)
- [Results of Widespread Prepayment Complex Review for Lower Limb Prostheses](#) (Posted 07/24/2014, 10/23/2014, 01/29/2015, 04/23/2015)
- [Lower Limb Prostheses Checklist for Physicians](#)

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

Historical Review Results

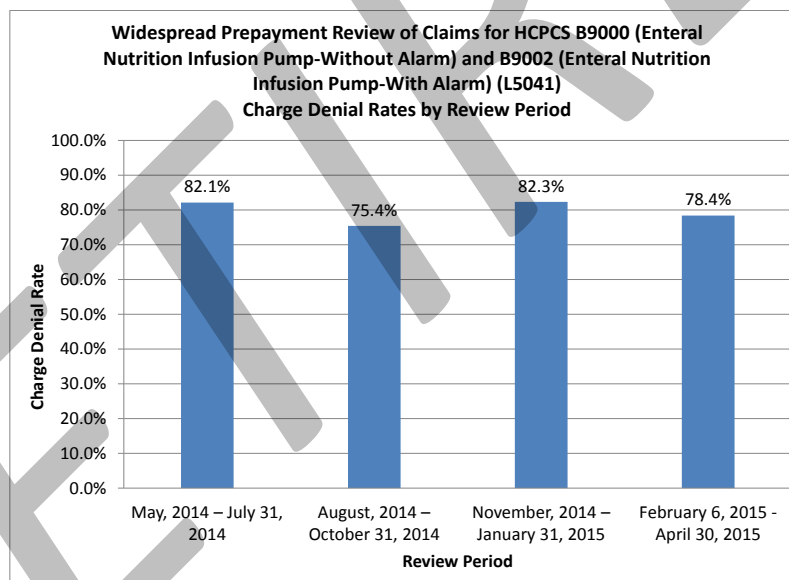
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The result of the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed is the Charge Denial Rate (CDR). The previous review included claims reviewed November 1, 2014 through January 31, 2015 and resulted in 82.3% Charge Denial Rate (CDR).

Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 and B9002. These findings include claims processed primarily from February 01, 2015 - April 30, 2015.

The review involved prepayment complex medical review of 818 claims submitted by 627 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 158 (19%) of the claims. For the remaining 660 claims, 169 claims were allowed and 491 were denied/partially denied resulting in a claim denial rate of 74% and a CDR of 78.4%.

Charge Denial Rate Historical Data



Reasons for Denial

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

Clinical Documentation Issues

- 26% of the denied claims did not have any medical record documentation submitted.
- 17% 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.
- 8% of the claims denied for statutory denial - did not meet prosthetic benefit requirement.

Proof of Delivery

- 11% of the denied claims had no Proof of Delivery (POD).
- 19% of the claims had incomplete delivery information.
 - No proof of receipt by the beneficiary.
 - Unable to match and verify through name, use of order numbers, and/or conflicting tracking numbers Method II POD.
 - Unable to determine delivery of all supplies to beneficiary

Detailed Written Order Issues

- 16% of the denied claims did not include a detailed written order.
- 8% of the denied claims had incomplete detailed written orders.
 - Date of the detailed order was incomplete (missing month or year)
 - Physician signature could not be authenticated

DME Information Form (DIF)

- 6% of the denied claims were missing a DIF.
- 1% of the denied claims were missing Enteral Pump HCPCS code on the DIF

Claim Examples

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

Example 1:

Received: Detailed written order, DIF, medical documentation.

Missing: Authenticated physician's signature on supplier generated detailed written order, signature date on the detailed written order, proof of delivery with signature and date.

Example 2:

Received: Detailed written order, proof of delivery.

Missing: DIF, Medical documentation that supports diabetic enteral formula and pump.

Example 3:

Received: Medical documentation that supports the prosthetic benefit and pump, proof of delivery.

Missing: Detailed written order, DIF.

Next Step

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

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

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

Questions and comments can be sent to the DME MAC Jurisdiction A Provider Compliance mailbox at:

dme_mac_jurisdiction_a_provider_compliance@hp.com

Educational References

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

- [Enteral Nutrition \(L5041\) LCD and related Policy Article \(A25229\)](#)

Medical Review

- [Results of Widespread Prepayment Review for B9000 \(Enteral Nutrition Infusion Pump-Without Alarm\) and B9002 \(Enteral Nutrition Infusion Pump-With Alarm\) \(L5041\)](#) (published 6/26/2014, 9/25/2014, 12/18/2014, 3/26/2015)
- [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- [CERT Physician Letter](#) - Enteral Nutrition
- [Enteral Nutrition Units of Service Calculator](#)
- [Frequently Asked Questions](#) (search word “enteral”)
- [Enteral Nutrition Supply Kits - Coverage Reminder](#)
- [CERT Error Articles](#)

Results of Widespread Prepayment Review for Milrinone (HCPCS Code J2260) (DRU)

Historical Review Results

This is the first DME MAC A medical review for Milrinone (HCPCS Code J2260). This medical review was initiated due to errors identified by a DME MAC A Medical Review Probe. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The Milrinone probe had a charge denial rate of 86.6%, which was noted in the article published November 26, 2014.

Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for Milrinone (J2260). These findings include claims processed primarily from February through April 2015.

The review involved prepayment complex medical review of 179 claims submitted by 44 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 77 (43%) of the claims. For the remaining 102 claims, 20 claims were allowed (20%) and 82 were denied/partially denied resulting in a claim denial rate of 80%. The overall CDR was 73.4%.

Primary Reasons for Denial

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

Clinical Documentation Issues

- 2% of the denied claims were missing clinical information to support medical necessity.
 - No medical records were submitted
- 34% of the denied claims did not meet all eight coverage criteria as listed in the External Infusion Pumps LCD (L5044):
 1. Dyspnea at rest or with minimal exertion is present despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g., hydralazine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant), and
 2. Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):
 - i. Dobutamine - - 2.5-10 mcg/kg/min
 - ii. **Milrinone - - 0.375-0.750 mcg/kg/min**
 - iii. Dopamine - - less than or equal to 5 mcg/kg/min, and
 3. Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), performed within 6 months prior to the initiation of home inotropic therapy showing (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b) at least a

20% increase in CI and/or at least a 20% decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion, and

4. There has been an improvement in beneficiary well-being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly, and
5. In the case of continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in the hospital, or in the case of intermittent infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management, and
6. Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home, and
7. The beneficiary is maintained on the lowest practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first 3 months of therapy, and
8. The beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy are routinely assessed and documented in the beneficiary's medical record.

Detailed Written Order

- 10% of the denied claims were missing the detailed written order.
- 25% of the denied claims had an incomplete or invalid detailed written order.

The following are specific issues identified:

- Missing a start date
- Missing the frequency of use
- Missing the route of administration
- Missing the number of refills

Proof of Refill Request Issues

- 36% of the denied claims were missing a proof of refill
- 10% of the denied claims had an incomplete or invalid proof of refill
 - Missing documentation demonstrating that supplies are nearly exhausted

Proof of Delivery Issues

- 8% of the denied claims were missing proof of delivery
 - 49% of the denied claims had an incomplete or invalid proof of delivery.
- The following are specific issues identified:
- Unable to associate the supplier proof of delivery records to a delivery service record (Method II)
 - Milrinone delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier(Method I)
 - Milrinone shipped either before or after the date of service of the claim when the item is shipped via a shipping service or delivery service (Method II) directly to a beneficiary
 - The units of service billed were more than the units of service delivered
 - The units of service billed and delivered were significantly higher than the amount of drug ordered.

DME Information Form (DIF) issues

- 9% of the denied claims were missing a DIF
- 2% of the denied claims had an invalid or incomplete DIF

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Milrinone (J2260) claims:

Example 1:

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and/or start date, detailed description of the item, treating physician's signature and date, dosage concentration, quantity to be dispensed, number of refills; clinical documentation that showed the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record; proof of refill request; proof of delivery; and a completed DIF.

Medical Review

Missing: The frequency of use and the route of administration on the detailed written order. Missing documentation on the proof of refill submitted that demonstrates that the beneficiary has nearly exhausted their supply of medication.

Example 2:

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and start date, detailed description of the item, treating physician's signature and date, dosage concentration, route of administration, frequency of use, quantity to be dispensed, number of refills; clinical documentation that showed the beneficiary was maintained on the lowest practical dose and efforts to decrease the dose of the drug were documented or the frequency/duration of infusion were documented during the first 3 months of therapy; the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record; proof of delivery; and a completed DIF.

Missing: There was no clinical documentation submitted from when the beneficiary initiated the Milrinone therapy, therefore the documentation did not demonstrate dyspnea at rest or with minimal exertion despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator; Cardiac studies by either invasive hemodynamic technique or using thoracic electrical bioimpedance (impedance cardiography), were performed within 6 months prior to the initiation of Milrinone showing (a) cardiac index (CI) was less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) was greater than or equal to 20 mm Hg before Milrinone infusion on maximum medical management and (b) at least a 20% increase in CI and/or at least a 20% decrease in PCWP during Milrinone infusion at the dose initially prescribed for home infusion; improvement in beneficiary wellbeing, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly; there was documented deterioration in clinical status when Milrinone was tapered or discontinued under observation in the hospital; life threatening arrhythmias (if any were noted) were controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home. No proof of refill submitted.

Example 3:

Received: Included in the claim was a detailed written order with beneficiary's name, physician's name, date of order and start date, detailed description of the item, treating physician's signature and date, dosage concentration, route of administration, frequency of use, quantity to be dispensed, number of refills; proof of refill request; proof of delivery; and a completed DIF.

Missing: The clinical documentation did not demonstrate that the beneficiary's cardiac symptoms, vital signs, weight, lab values, and response to therapy were routinely assessed and documented in the beneficiary's medical record.

Next Step

Based on the results of this prepayment review, DME MAC A will continue with a pre-pay complex widespread medical review of claims for Milrinone (HCPCS J2260).

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 Milrinone claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements.

- [External Infusion Pumps LCD \(L5044\) and Policy Article \(A19713\)](#)
- [Results of Prepayment Probe for Milrinone \(J2260\)](#) (published 11/26/2014)

- [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- [Live Line Chat](#) (Monday 9:00am - 11:00am and Thursday 1:00pm - 3:00pm) - The Monday chat sessions provide the opportunity to ask billing, policy, documentation and other general questions to the Outreach & Education Team

Results of Widespread Prepayment Review for Nebulizers (HCPCS Code E0570) (SPE)

Historical Review Results

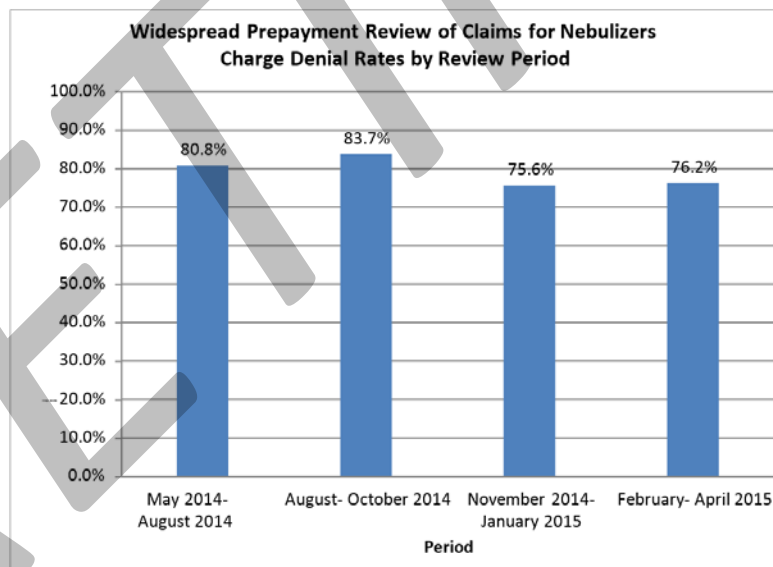
This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered the period of November 2014 through January 2015, and reported a CDR of 75.6%.

Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from February 2015 through April 2015. The review involved prepayment complex medical review of 2,024 claims submitted by 627 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 399 (20%) of the claims. For the remaining 1,625 claims, 306 claims were allowed (19%) and 1319 were denied/partially denied resulting in a claim denial rate of 81%. The overall CDR was 76.2%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Clinical Documentation Issues

- 22% of the denied claims were missing clinical documentation to support reasonable and necessary.
 - No medical records were submitted

Medical Review

- 35% of the denied claims had insufficient or incomplete clinical documentation.
The following are specific issues identified with clinical documentation:
 - Clinical documentation did not support reasonable and necessary use of a nebulizer
 - Clinical documentation submitted did not mention a payable medical condition
 - Clinical documentation submitted did not contain enough detailed clinical information to demonstrate that the item is reasonable and necessary
 - Illegible copy of documentation submitted
 - Physician signature did not meet signature requirements including:
 - Missing physician's handwritten or electronic signature
 - Illegible physician signature with no printed name or signature log submitted
 - Unsigned typed note with physician's typed name only

Written Order Prior to Delivery (WOPD)

- 3% of the denied claims did not contain a written order prior to delivery.
- 38% of the denied claims had an incomplete or invalid written order prior to delivery.
The following are specific issues identified:
 - Missing the prescribing practitioner's National Provider Identifier (NPI)
 - Ordering practitioner signature date was after the item(s) were delivered
 - Insufficient evidence (i.e. date stamp, fax date, etc.) within the documentation to show that the supplier received the written order prior to delivering the item(s)

Proof of Delivery Issues

- 5% of the denied claims were missing proof of delivery.
- 13% 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, physician's NPI number, clinical notes and proof of delivery

Missing: The physician's signature date on the WOPD is after the item(s) were delivered. Insufficient evidence (i.e. Date stamp, fax date, etc.) within the claim submitted to show that the supplier received the WOPD prior to delivering the item(s). Proof of delivery submitted shows that the item(s) were delivered before the date of service.

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: Invalid alteration to the physician's NPI number on the WOPD. Insufficient evidence (i.e. Date stamp, fax date, etc.) within the documentation submitted to show that the supplier received the WOPD prior to delivering the supplies

item(s). Proof of delivery missing a sufficiently detailed description (e.g., brand names, serial number, narrative description) of an E0570 nebulizer compressor.

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 \(A24944\)](#)
- [Results of Widespread Prepayment Review of Claims for E0570](#): posted June 26, 2014, September 25, 2014, December 18, 2014, March 26, 2015
- [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- [CERT Error Articles](#)
- [Frequently Asked Questions](#) (search word "nebulizer")
- [Face-to-Face and Written Order Requirements for High Cost DME](#) - Dear Physician Letter
- [Live Line Chat](#) (Monday 9:00am - 11:00am and Thursday 1:00pm - 3:00pm) - The Monday chat sessions provide the opportunity to ask billing, policy, documentation and other general questions to the Outreach & Education Team

Results of Widespread Prepayment Review of Claims (Continuous Positive Airway Pressure Devices) HCPCS Code E0601 (SPE)

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered claims reviewed from January 2015 through March 2015, and reported a CDR of 67.4%.

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 April 2015 through June 2015.

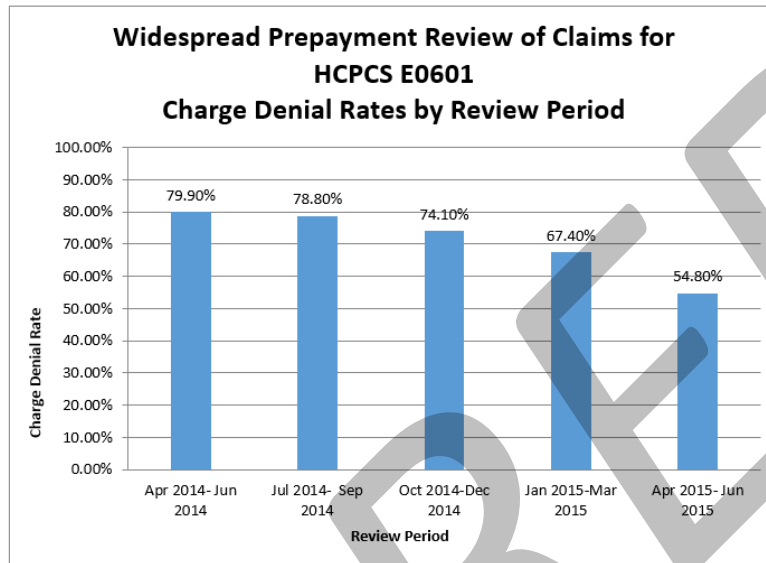
This review involved prepayment complex medical review of 1522 claims submitted by 352 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 305 (20%) of the claims. Of the 1217 claims for which responses were received,

Medical Review

439 claims were allowed and 778 were denied/partially denied. This resulted in a claim denial rate of 64%. The overall CDR was 54.8%.

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

- 9.3% of the denied claims had no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement. Scenarios included:
 - A. Beneficiaries seeking initial coverage of a PAP device
 - B. Beneficiaries seeking PAP replacement following the 5 year RUL
 - C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare
- 2.3% 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.
- 3.5% of the denied claims had a Face-to-Face clinical evaluation dated after the Sleep Study. An E0601 device is covered when the beneficiary has a Face-to-Face clinical evaluation by treating physician prior to the sleep test to assess the beneficiary for Obstructive Sleep Apnea per PAP LCD.

Insufficient Clinical Documentation

- 12.7% 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).
 - Clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued to benefit from sleep therapy.
 - Insufficient clinical documentation 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.
- 4.6% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.

Detailed Written Order/Written Order Prior to Delivery Issues

- 3% of the denied claims did not include the Detailed Written Order.
- 25.8% of the denied claims had an incomplete Written Order Prior to Delivery for PAP device E0601.
Included in these results for incomplete Written Order Prior to Delivery were orders which were missing either:
 - A. Beneficiary's name
 - B. The E0601 PAP device ordered
 - C. The prescribing practitioner's National Provider Identification (NPI)
 - D. The signature of the prescribing practitioner
 - E. The date of the order
 - F. Signature date.
 - G. A date of receipt demonstrating supplier received the Detailed Written Order on or before the Delivery
- 65.5% of the claims had an incomplete Detailed Written Order for PAP accessories.
Included in these for incomplete Detailed Written Order were orders which were missing either:
 - A. Beneficiary's name
 - B. Physician's name
 - C. Date of the order and the start date, if start date is different from start of order
 - D. Detailed description of item(s) ordered
 - E. Physician signature and signature date

Also included in this calculation are orders which contain incompatible combination of items that did not have a valid detailed written order with the specific items provided

Sleep Study Documentation Issues

- 8.2% of the denied claims did not include a copy of the original Sleep Test that meets the Medicare coverage criteria.
- 9% of the denied claims had no practitioner's signature on the Sleep Test that meets the Medicare coverage criteria.
- 3.4% of the denied claims were missing Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 6.6% of the denied claims did not include evidence of training on the PAP device.
- 14.3% of the denied claims did not include evidence of beneficiary training (by entity conducting the test) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a Face-to-Face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 4.1% of the denied claims were missing Proof of Delivery.
- 8.9% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature.

Claim Examples

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

Example 1:

Received: Included in this claim are a Detailed Written Order/Written Order Prior to Delivery, a Sleep Test that meets the Medicare coverage criteria, evidence of Training on the PAP device, Proof of Delivery, and Face-to-Face clinical evaluation by the treating physician.

Missing: Detailed Written Order submitted lists many different items, not all of which may be needed by an individual beneficiary, creating incompatible combinations. Order is missing affirmative indicators which show the physician's selected item.

Example 2:

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

Missing: Proof of Delivery is missing a sufficient description of item(s) delivered. Unable to identify item(s) delivered.

Medical Review

Example 3:

Received: Included in this claim are a Detailed Written Order/Written Order Prior to Delivery, a Face-to-Face clinical evaluation by treating physician, Home Sleep Study, Proof of Delivery, and evidence of Training on the PAP device.

Missing: Documentation submitted did not include information to support that the beneficiary received instruction for the application and use of a portable sleep monitoring device either by Face-to-Face, video or telephonic instruction.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed for Continuous Airway Pressure Devices (E0601). Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor. DME MAC Jurisdiction A performs ongoing assessment of the effectiveness of its prepayment widespread reviews.

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

Questions and comments can be sent to the DME MAC Jurisdiction A Provider Compliance mailbox at:

dme_mac_jurisdiction_a_provider_compliance@hp.com

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables the direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: <http://www.medicarenhic.com/dme/mr.aspx>

Educational References

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

- [Positive Airway Pressure \(PAP\) Devices for the Treatment of Obstructive Sleep Apnea \(L11528\)](#)
 - [Results of Widespread Prepayment Review of Claims for HCPCS E0601](#) (Continuous Positive Airway Pressure Devices) (Posted: 05/29/2015, 02/26/2015, 11/21/2014, 09/18/2014, 05/29/2014, 02/27/2014, 11/22/2013, 08/30/2013, 05/31/2013, 02/28/2013, 11/30/2012, 08/24/2012, 04/20/2012, 12/22/2011, 08/19/2011, 3/4/2011, 07/02/2010)
 - [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
 - [CERT Documentation Checklist](#)
 - [CERT Error Articles](#)
 - [Physician's Corner Check List](#)
-

Results of Widespread Prepayment Review of Claims for Lumbar-Sacral Orthoses, HCPCS Codes L0631/L0637 (O&P)

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered the period of December 2014 through February 2015 and resulted in a CDR of 82%.

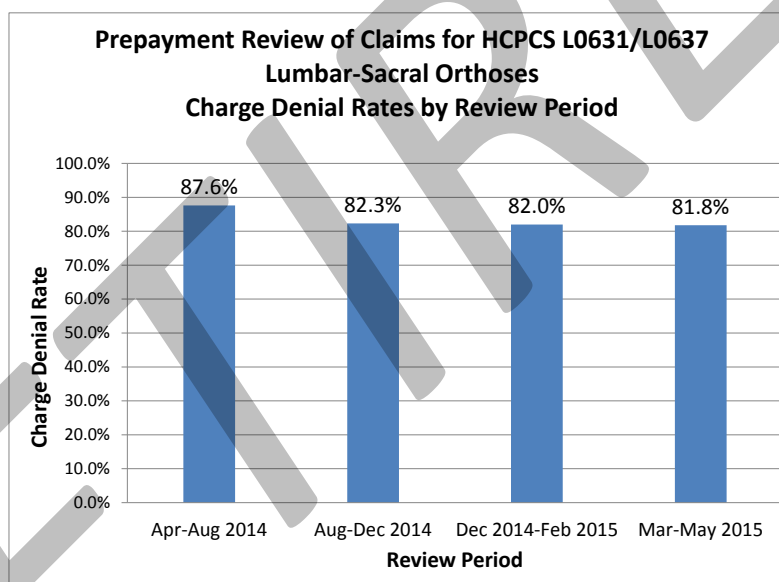
Current Review Results

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

The review involved prepayment complex medical review of 1,384 claims submitted by 423 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 582 (42%) of the claims. For the remaining 802 claims, 148 claims were allowed and 654 claims were denied resulting in a claim denial rate of 82%. The overall CDR was 81.8%.

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) (11%)
- Denied claims included an incomplete DWO (26%)
 - DWOs submitted were not legible and/or did not list beneficiary name (2%)
 - DWOs missing start date and/or signature date (11%)
 - DWOs were missing a detailed description of the requested Lumbar Sacral Orthotic (s) (14%)

Medical Record Documentation Issues

- Denied claims missing the clinical documentation to support medical necessity (9%)
- Denied claims upon review of clinical documentation (23%)

Medical Review

- Medical documentation was not authenticated by the clinician conducting the exam (7%)
- 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 (16%)

Proof of Delivery Issues

- Denied claims were missing the Proof of Delivery (POD) (10%)
- Proof of Delivery (POD) included delivery documentation was missing required elements (19%)
 - Delivery documentation (Method 1) did not include signature of beneficiary or Beneficiary's representative; unable to determine if beneficiary Received items billed (3%)
 - Dates of service do not match shipping/receipt dates for items, as defined within the LCD (L11470) (3%)
 - Delivery documentation does not include delivery address. (5%)
 - Delivery documentation does not specifically describe Lumbar Sacral Orthotic(s) delivered either with a HCPCS code or a detailed description.(9%)

Claim Examples

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

Example 1:

Received: The supplier submitted a completed DWO, clinical documentation, and POD.

Missing: Clinical documentation submitted was dated after the date of service, and must be dated prior to the date of service to support medical necessity for the provided item.

Example 2:

Received: The supplier submitted a completed a DWO, POD and a letter of medical necessity.

Missing: Clinical documentation to support the beneficiary's medical need for the requested item. Clinical notes are required as part of the submitted documentation. For purposes of Medicare reimbursement, attestation letters and letters of necessity are not part of the medical record.

Example 3:

Received: The supplier submitted a DWO, which included the treating clinician's signature, date of clinician's signature, detailed description of the requested item, and start date of order. The supplier submitted radiology reports and lab tests to support medical necessity, and a valid proof of delivery.

Missing: The DWO was missing the beneficiary's name. Physician's progress notes required to support medical necessity were missing. Radiology and lab reports may be used in conjunction with the physician's documentation to determine medical necessity, but by themselves are insufficient to support medical necessity.

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 \(L11470\)](#)
- [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
- [Results of Prepay Probe for Lumbar-Sacral Orthoses](#)

Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (OXY)

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed result is the Charge Denial Rate (CDR). The previous quarterly findings covered the period of January 01, 2015 through March 31, 2015 and resulted in a CDR of 65%.

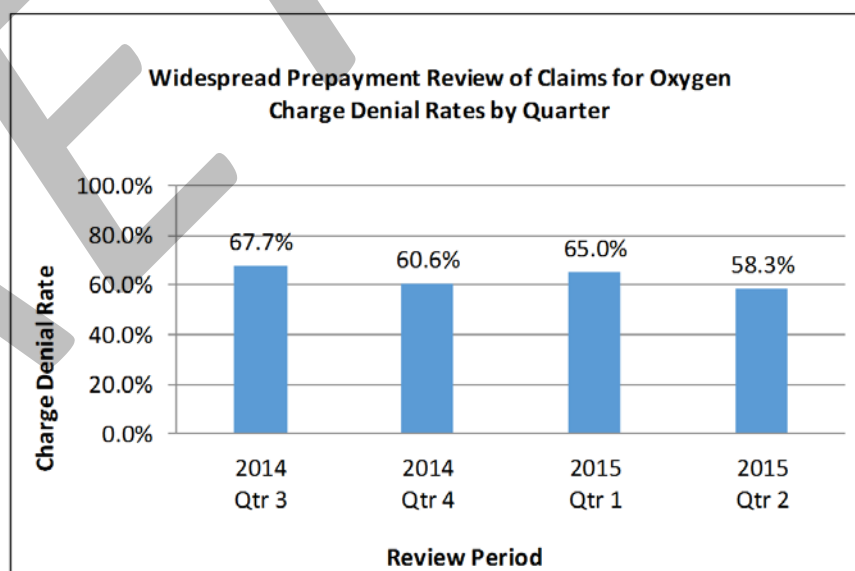
Current Review Results

The DME MAC Jurisdiction A has completed a widespread prepayment review of claims for Oxygen and Oxygen Equipment (HCPCS codes E1390, E0431, and E0439). These findings cover claim process dates primarily from April 01, 2015 through June 30, 2015.

The review involved prepayment complex medical review of 1,063 claims submitted by 166 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 580 (55%) of the claims. For the remaining 483 claims, 152 claims were allowed and 331 were denied resulting in a claim denial rate of 69%, and a CDR of 58.3%.

Charge Denial Rate Historical Data

The following percentages depict the CDR from previous quarters to current:



The Coverage Indications, Limitations and/or Medical Necessity section of the Oxygen and Oxygen supplies LCD states:

Medical Review

Home oxygen is covered only when both the reasonable and necessary criteria are met. Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated in the LCD, and
3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
 - a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
 - b. If the qualifying blood gas study is not performed during an inpatient stay, the reported test must be performed while the beneficiary is in a chronic stable state - i.e. not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11468 and related Policy article for additional information.

Primary Reasons for Denial

The following are the primary reasons for denial.

Written Order Prior to Delivery Requirements Not Met (49%)

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 1, 2014 for the following reasons:

- No evidence, by date stamp or similar, that the supplier received the detailed written order prior to delivery (38%)
- Detailed written order was missing a detailed description of the DME item(s) ordered (36%)
- Detailed written order was signed after the date of delivery (31%)
- Detailed written order was received after the date of delivery (23%)
- Detailed written order was missing the prescribing practitioner's NPI (17%)
- Detailed written order was missing the order date (6%)
- Correction was made to the detailed written order without the author's initials and the date of the correction (6%)
- No detailed written order was submitted (5%)
- Detailed written order was missing valid proof of receipt, by date stamp or similar (1%)
- Detailed written order was missing the prescribing practitioner's name (1%)

Missing Documentation (30%)

Missing required physician visit per LCD L11468:

- 15% - Missing treating physician visit within 30 days prior to the initial certification date

Missing qualifying blood gas study per LCD L11468:

- 4% - No medical documentation to support the blood gas study reported on the CMN

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

- 8% - No initial CMN submitted or initial CMN was invalid

Missing valid proof of delivery per LCD L11468:

- 3% - Missing valid proof of delivery
 - Proof of delivery not submitted
 - Date of delivery did not match the initial date of service
 - Proof of delivery missing the items delivered

Clinical Documentation Issues (21%)

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

- 6% - 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
- 5% - No indication in the medical documentation of the presence of a severe lung disease or hypoxia-related symptoms
- 4% - 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
- 3% - Replacement oxygen requirements not met
 - Missing the RA modifier and a narrative explanation of why the equipment was replaced
- 1% - Medical documentation did not demonstrate that the beneficiary was tested while in a chronic stable state
- 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 07/10/14

Codes Billed: E1390, E0431

Documentation received: Proof of delivery dated 07/10/14; detailed written order dated 07/09/14; physician progress notes dated 06/17/14; supplier forms; oxygen saturation testing results supporting the test results documented on the CMN; initial CMN dated 07/10/14

Missing: A detailed description of the item ordered and proof of receipt prior to delivery on the detailed written order; documentation in the medical record of the presence of a severe lung disease or hypoxia-related symptoms; the beneficiary's name or other identifying information on the oxygen saturation testing results

Example 2:

DOS 12/17/14

Codes Billed: E1390, E0431

Documentation received: Initial CMN dated 12/17/14 and signed 02/20/15, which is also serving as the detailed written order; letter of attestation from the physician dated 12/03/14; proof of delivery dated 12/17/14

Missing: A detailed written order signed and received prior to delivery of the items ordered; medical documentation of an in-person visit with the physician dated within 30 days prior to the initial certification date; medical documentation to support the results of the oxygen saturation test results on the CMN

Example 3:

DOS 02/20/15

Codes Billed: E1390, E0431

Documentation received: Detailed written order signed and received 02/10/15; hospital progress notes dated 02/10/15 documenting the need for oxygen therapy

Missing: An initial CMN; a handwritten or electronic signature to authenticate the progress notes; proof of delivery from the supplier

Next Steps

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

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

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

Medical Review

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

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables direct access to comprehensive information relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

Decision Desktop can be accessed through the following link: <http://www.medicarenhic.com/dme/mr.aspx>

Educational References

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

- [The Oxygen and Oxygen Equipment Local Coverage Determination \(LCD\); L11468 and related Policy Article \(A33768\)](#)
- [DME MAC Jurisdiction A Supplier Manual](#) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
- [CERT Error Articles](#)
- [Physician Letter](#) - Home Oxygen Initial Qualification Testing
- [Physician Letter](#) - Face-to-Face and Written Order Requirements for High Cost DME
- [Oxygen Highlights & Headlines](#)
- [Frequently Asked Questions](#) (search word oxygen)
- [Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment \(HCPCS Codes E1390, E0431, and E0439\)](#) (Posted: 05/29/2015, 02/26/2015, 11/21/2014, 09/18/2014, 05/29/2014, 02/25/2014, 11/27/2013, 08/30/2013, 05/17/2013, 02/08/2013, 10/12/2012, 06/29/2012, 03/02/2012, 11/04/2011, 08/26/2011, 11/05/2010, 06/09/2010)
- [Results of Documentation Compliance Review \(DCR\) of Claims for Oxygen Equipment, HCPCS E1390](#)

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

Enhancements to the Interactive Voice Response System for Same and Similar Functionality A, L, and V Codes (GEN)

NHIC, Corp. is pleased to announce our most recent interactive voice response (IVR) system enhancement: Phase I same/similar functionality for A, L, and V codes. This new feature allows suppliers of orthotics, prosthetics, and supplies to obtain same or similar claim information for the majority of for Healthcare Common Procedure Coding System (HCPCS) codes that begin with letters A, L, or V. Suppliers will still need to speak with a live customer service representative to obtain same and similar claim information on the following HCPCS codes: A4218, A7018, L0641-L0643, L0468-L0651, L1833, L1848, L8039, and L8048-L8049. These codes will be added to the IVR during phase two of the IVR enhancement. Look for more information regarding phase two in future announcements.

If you would like to obtain same or similar claim information for HCPCS codes that begin with letters A, L, or V select option 7 for Same or Similar.

- Enter the **Beneficiary Medicare Number, Beneficiary Name, Beneficiary Date of Birth** (MMDDYYYY or MM/DD/YYYY format), and **HCPCS code** you wish to search

The system will search the Jurisdiction A DME MAC local records for processed claims. The claims information displayed will include claims that have processed within the same HCPCS code range for the specific HCPCS code entered.

The IVR will playback a list of processed claims:

- Most recently processed claims within one (1) year for HCPCS codes beginning with the letter A
- Most recently processed claims within five (5) years for HCPCS codes beginning with the letters L and V

Note: *If the claim information provided is not for a claim you submitted you will need to contact the supplier indicated from the same/similar playback. To obtain the telephone number, you can visit the NPPES website and enter the supplier's NPI number.*

The IVR will provide the following information found in the Jurisdiction A DME local records:

- Same or similar HCPCS code and modifier
- Last day item was billed
- Supplier's name
- Supplier's NPI number

For L codes not listed in a medical policy, suppliers must check each individual HCPCS code to obtain same or similar claim information.

Additional information related to the DME MAC A IVR, including the IVR User Guide, can be found on our web site at:

<http://www.medicarenhic.com/dme/contacts.aspx>

Affordable Care Act (ACA) 6407 - Supplier Frequently Asked Questions Joint DME MAC Article (GEN)

Due to the high volume of inquiries regarding ACA 6407 requirements, the DME MAC Provider Outreach Departments developed the following "Supplier Frequently Asked Questions" document.

ACA 6407

Q1: What is ACA 6407?

A1: "ACA" refers to the *Affordable Care Act* and "6407" is the specific section of the Act containing details of certain HCPCS codes which require a face-to-face (F2F) encounter with a physician and a valid, written order prior to delivery (WOPD). Suppliers should review the DME MAC Joint Publication titled "Face-to-Face Examination and Prescription Requirements

Outreach & Education

Prior to the Delivery of Certain DME Items Specified in the *Affordable Care Act - Revised*” for a complete list of affected HCPCS codes.

Q2: When will CMS enforce the F2F requirements and WOPD?

A2: Section 6407 of the ACA was implemented on 7/1/2013 and the DME MAC contractors began enforcement of the WOPD and NPI requirements for dates of services on or after 1/1/2014. Enforcement by the DME MACs, of the F2F requirement, has been postponed by CMS until a future date.

Q3: What is the difference between “implementation” and “enforcement” regarding ACA 6407?

A3: Implementation is the date that the provisions of ACA 6407 became effective (7/1/2013). Enforcement is when DME MACs begin auditing claims to determine that suppliers are following the provisions of ACA 6407.

Q4: Is the Comprehensive Error Rate Testing (CERT) contractor recognizing the delay in the enforcement of the F2F requirements?

A4: No. CERT has not been instructed by CMS to delay the enforcement of the F2F requirements; therefore, claims reviewed by the CERT contractor that are not compliant with the F2F requirements may result in denial or recoupment. If the CERT contractor denies for this reason, suppliers may submit a request for a redetermination.

Face-to-Face Encounter

Q5: Do suppliers need to obtain a new F2F encounter every six months?

A5: No, there is no requirement under ACA 6407 that a supplier obtain documentation of a new F2F encounter on a periodic basis. A F2F encounter within 6 months prior to the prescription date is required for any order obtained on or after 7/1/2013.

Q6: What if the policy has a requirement for a F2F encounter within 30-days for an item that is also on the ACA list? Must the F2F encounter be performed within the 30-days or within six months?

A6: If the LCD requires that a F2F encounter must be performed within 30-days then that requirement must still be met. The ACA F2F requirement does not replace any existing LCD timing requirements for F2F encounters. Suppliers must meet both the ACA requirements and any requirements outlined in the applicable LCD. In this example, by meeting the LCD requirement, the ACA requirement is automatically met.

Q7: Does the ACA F2F requirement apply to orthotics and prosthetics?

A7: No. ACA 6407 applies to certain DME HCPCS only. Suppliers should review the DME MAC Joint Publication titled “Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the *Affordable Care Act - Revised*” for a complete list of affected HCPCS codes.

Q8: Must the F2F encounter specifically mention the DME item being ordered?

A8: No. However, in order for the ACA requirements to be met, the F2F encounter must address a medical condition that supports the item ordered.

Q9: Does the F2F encounter with the physician need to specifically state the beneficiary was there for a F2F encounter for the specific DME item, or can the beneficiary have a visit and the physician’s notes show physical limitations that justify the specific DME item?

A9: In contrast to power mobility devices, items encompassed by the ACA 6407 requirements do not require that the F2F encounter specify that the visit was expressly for the purpose of documenting the need for the specific item of DME. However, as noted above, there must be sufficient documentation in the medical records to support the need for the item ordered.

Q10: Can the F2F documentation be electronically signed by the physician?

A10: CMS has published instructions to contractors allowing electronic signatures. CMS has not provided detailed guidance defining the format or contents of an electronic signature. CMS does allow contractors to authenticate electronic signatures. We recommend that when suppliers obtain electronic records that the electronic signatures are clearly identifiable and provide comparable information as is required for a non-electronic signature for the same document type. Refer to each LCD and the *Supplier Manual* for additional information regarding signatures.

Written Orders Prior to Delivery/Face-to-Face

Q11: What elements must be included on a WOPD for an item(s) associated with ACA F2F HCPCS code list?

A11: The WOPD must include all required elements for a standard detailed written order and additionally must include the prescribing practitioner's NPI number. The elements would need to include:

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

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

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

Q12: Can the WOPD and the F2F encounter be on the same document as long as it is in the medical record?

A12: No. The F2F encounter and order must be two separate documents. The F2F must be incorporated into the medical record and the order would need to be a separate document from the medical record.

Q13: If the beneficiary is in the hospital, can the attending physician conduct the F2F encounter and the beneficiary's primary care physician complete the WOPD?

A13: Yes. The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:

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

Q14: Can the F2F encounter, WOPD and the delivery of the DME item all be completed in the same day?

A14: Yes. However, the date stamp (or similar) indicating the date of receipt of the documents must clearly reflect that the F2F and WOPD were received prior to delivery of the item.

Documenting a Receipt Date

Q15: Must the F2F encounter and WOPD be date stamped by the supplier upon receipt?

A15: A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the F2F encounter and the completed WOPD with the prescribing physician's signature and a signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Q16: Does every page of the F2F encounter need to be date stamped?

A16: As long as it is clear that the record includes all pages, a single date stamp or similar is sufficient. When submitting the documentation for review, all pages need to be submitted to support the date stamp or similar.

Q17: What methods are acceptable for documenting a receipt date?

A17: 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:

- Hardcopy date stamps
- Hand-written dates
- Facsimile headers and electronic receipt dates (see question 18 for additional information)

Outreach & Education

Regardless of the method used, it must be clear to contractor staff reviewing the claim that the date received meets the requirements in the applicable LCD.

Q18: Can a fax header be used to document receipt of the WOPD and the F2F encounter prior to delivery, or must we use a date stamp?

A18: We highly recommend the use of a date stamp to document receipt of the WOPD and F2F. If a fax date or equivalent is used, the information must be legible, it must be clear that the supplier is the one that received the order and F2F on the date listed. Possible ways to document this would be to also submit a copy of the fax cover sheet or the header listing the “to” and “from” sender names.

Written Order Prior to Delivery - Corrections to Document

Q19: What happens if there is an error on the WOPD or the F2F document and it is not noticed until after the equipment is delivered to the beneficiary?

A19: WOPD is a long-standing statutory requirement for certain items of DME. The list of items subject to WOPD was expanded by the *Affordable Care Act* Section 6407. Medicare policy stipulates that a WOPD that is missing an element is not “curable” by a provider (i.e., a provider cannot make corrections to a WOPD) except as outlined below.

- I. If errors in the WOPD are found **prior** to delivery, the supplier has two options:
 - A. The WOPD may be properly amended following the guidance in the *Medicare Program Integrity Manual* (Internet-Only Manual, Publication 100-08), Chapter 3, Section 3.3.2.5; or,
 - B. A new WOPD may be created and sent to the physician for signature and date.
- II. If errors in the WOPD are found after delivery of the item, the supplier has two options:
 - A. If the error is discovered prior to claim submission, the original supplier may recover the delivered item(s), obtain a compliant, complete WOPD and then may redeliver the item(s) to the beneficiary; or,
 - B. If the error is discovered after submitting a claim, the original supplier can recover their items and a new supplier must complete the transaction after complying with all requirements.

Because WOPD is a statutory requirement, claims denied because of a defective WOPD result in a beneficiary liability determination. Suppliers are strongly encouraged to review their WOPD documentation carefully **prior** to delivery to ensure that all the requirement elements are present on the document.

Q20: Does Medicare consider a different location (with a different NPI or PTAN) another supplier?

A20: Yes. A different location of the same company is considered a “new” supplier as that location operates and bills the Medicare program under a separate NPI/PTAN.

Resource Content

- [MM8304](#)
- [Medicare Program Integrity Manual\(Internet-Only Manual, Publication 100-08\), Chapter 3, Section 3.3.2.5](#)

Joint DME MAC Articles:

- [Face-to-Face Examination and Prescription Requirements Prior to the Delivery of Certain DME Items Specified in the Affordable Care Act](#)
- [ACA 6407 Requirements - Corrections and Amendments To The Face-To-Face Visit And Written Order Prior To Delivery](#)
- [Face-To-Face Requirements for Orders Used to Obtain Medicare Payment on ACA Items](#)
- [ACA Requirement for Indicating Receipt Date of Documentation](#)
- [In-Person Visit Requirement for Section 6407 of the Affordable Care Act - Clarification](#)
- [Dear Physician Letter: Face-to-Face and Written Order Requirements for High Cost DME](#)

Second Quarter 2015 - Top Claim Submission Errors

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2015, are provided in the following table.

Note: The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 Rejected for relational field Information within the HCPCS	86,076	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	18,509	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.351.2400.SV101-3.040 The procedure code modifiers in SV101 must not be duplicated within the same detail service line.	12,481	The procedure code modifiers in SV101 must not be duplicated within the same detail service line.
X222.087.2010AA.NM109.050 Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	11,173	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 The diagnosis code pointed to by diagnosis code pointer 1 (SV107-1, SV107-2, SV107-3, or SV107-4) is invalid for the claim line date of service.	10,063	If 2400.SV107-1 through SV107-4 "1" and 2300.HI01-1 is "BK" then 2300.HI01-2 must be a valid ICD-9-CM Diagnosis code on the date in 2400.DTP03 when DTP01 = "472", based on the ICD-9-CM Diagnosis Code list.
X222.226.2300.HI01-2.130 Duplicate diagnosis codes cannot be sent on the same HI segment in a claim.	9,841	If 2300.HI01-1 equals BK or ABK the Diagnosis codes within this HI segment must not be duplicated.
X222.094.2010AA.REF02.050 Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	9,469	Verify that the information you are submitting matches the information on file with the NPES and NSC.
X222.351.2400.SV101-3.020 Procedure Modifier must be valid for the Service Date. (DTP01 = "472")	7,827	2400.SV101-3 must be valid procedure modifier on the date in 2400.DTP03 when DTP01 = "472".
X222.087.2010AA.NM109.030 Invalid information in the Billing Provider's NPI	7,592	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 NPES web site matches the information at the NSC.
X222.351.2400.SV101-7.020 This Claim is rejected for relational field Information within the Detailed description of service	6,655	Description must be present when Procedure Code requires a description/additional information.

Second Quarter 2015 - Top Return/Reject Denials

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the second quarter of 2015. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from April through June 2015.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4, N519 The procedure code is inconsistent with the modifier used or a required modifier is missing.	Item 24D - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	31,878
OA109, N418 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	12,702
CO 182, N517 Procedure modifier was invalid on the date of service	Item 24d - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	8,896
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.	2,987
CO16, N350 Claim/service lacks information which is needed for adjudication.	Item 19 - Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code.	2,653
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.	1,755
CO 16, M79 Missing / incomplete / invalid charge	Item 24F - Did not complete or enter the appropriate charge for each listed service.	1,414
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.	1,193
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).	1,188
CO 4, MA13, MA130, M114 The procedure code is inconsistent with the modifier used, or a required modifier is missing.	Item 24D - The claim contains incomplete and/or invalid information. The claim must be corrected and re-submitted.	658

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:

In June of 2015 chapters 1, 3, 4, 6, 10, and Appendix A of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

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.

Updating Supplier Records (GEN)

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

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

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

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

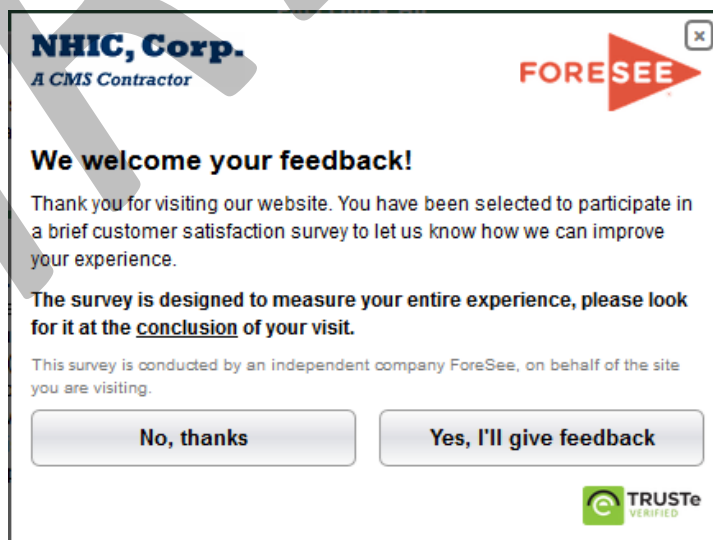
Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey

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

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

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



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



Join the NHIC, Corp. DME MAC A ListServe!

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

RETIRED

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

outreach-education@hp.com

Claims Submissions

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

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

Written Inquiries

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

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

Overpayments

Refund Checks:

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

Payment Offset Fax Requests: 781-741-3916

Note: Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form

Appeals and Reopenings

Telephone Reopenings: 844-687-2656

Faxed Reopenings: 781-741-3914 or 781-741-3842

Redetermination Requests Fax:

781-741-3118 or 781-741-3840

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

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

September 2015
Number 37

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



**Durable Medical Equipment
Medicare Administrative Contractor**

DME MAC Jurisdiction A offers our quarterly bulletin, the *DME MAC Jurisdiction A Resource*, in electronic format via our Web site, where copies can be printed *free of charge*. To access the bulletin, go to the "Publications" section of our Web site at: <http://www.medicarenhic.com/dme/pubdownload.aspx>. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServe, our electronic mailing lists by visiting: <http://www.medicarenhic.com/dme/listserve.html>

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is \$65.00 for hardcopy and \$172.00 for CD-ROM. *This subscription includes the four quarterly bulletins published during the calendar year of (YEAR) - March, June, September and December.* Complete this form and submit with payment, via check only, to the address listed below.

* The CD-ROM version of the bulletin is a Portable Document Format (PDF) file. To view PDFs, you must have Adobe® Acrobat® Reader® installed on your computer.

Name: _____ NPI #: _____

Mailing Address: _____ City: _____

Phone Number: _____ State: _____ Zip: _____

Reason for requesting a
hardcopy of the *Resource*: _____

I wish to receive: Hardcopy - \$65 per year ☐ CD-ROM - \$172 per year ☐

By completing this form and signing below, I certify I do not have access to the Internet, or have some other technical barrier, preventing me from accessing the *DME MAC Jurisdiction A Resource* and therefore request I receive an annual hardcopy subscription. I understand I will have to renew my subscription annually to continue receiving hardcopy of *DME MAC Jurisdiction A Resource*.

Enclose your check payable to:

NHIC, Corp.

Mail your completed form with payment to:

**NHIC, Corp.
Cash Accounting / DME Subscription
75 Sgt William B Terry Drive
Hingham, MA 02043**

Signature: _____ Date: _____

NHIC, Corp.

**NHIC, Corp. DME MAC Jurisdiction A
A CMS CONTRACTOR**

NHIC FORMS AND LETTERS PRIVACY NOTICE

NHIC Corp. (NHIC) is committed to ensuring that its users' privacy is protected; in particular, the protection of personally identifiable information (PII) is provided to all beneficiaries of NHIC Medicare programs by developing and applying privacy policies that comply with law and regulations -- and are integrated and implemented within the operations of all NHIC programs. The authority for this commitment is derived from a number of laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), the Privacy Act of 1974, CMS' Information Security Acceptable Risks Safeguards (ARS) 2.0, CMS' Risk Management Handbook (RMH) on privacy, and other CMS contract requirements. Finally, NHIC's commitment to privacy protection is consistent with its shared value of respect for individuals, which is grounded in the ethical principal of autonomy, an individual's rights and responsibilities related to self-determination.

Types of Personally Identifiable Information (PII) NHIC Collects

NHIC collects personally identifiable information (PII) -- for example, name, email and home or business addresses, telephone number, and Social Security number or Provider ID -- for the sole purpose of meeting its obligations with the federal Centers for Medicare and Medicaid Services (CMS) as a Medicare Administrative Contractor (MAC).

How NHIC Uses the Personally Identifiable Information (PII) It Collects

NHIC uses the PII it collects to perform its healthcare operations, including determination of eligibility of claims for treatment, as well as for equipment or supplies; identification of secondary insurance coverage; arranging electronic funds transfer (EFT); following up of appeals; and responding to requests for customer service. Disclosing this information is voluntary on the part of beneficiaries and providers seeking coverage of their claims; beneficiaries or providers unwilling to disclose this information in whole or part, as required by CMS, will not be able to obtain coverage. Moreover, NHIC, performing as a "business associate of CMS" with respect to the HIPAA Privacy Rule, may share PII with CMS without authorization of the beneficiary or provider. It may also use this information for various administrative functions related to quality improvement and contract oversight.

How NHIC Protects Your Personally Identifiable Information (PII)

NHIC protects and safeguards the PII by storing it on its own secure servers that 1) are located in a secure facility and 2) accessible only by staff with a business need to use it. On occasion, this collected information is also requested by, and shared with, the Centers for Medicare & Medicaid Services (CMS) and its agents, for use in contract activities. In accordance with CMS regulations, collected information is *not* disposed of; instead, it is kept on an indefinite basis.

NHIC's Privacy Policy Feedback

We welcome questions, comments, and suggestions about our privacy policy, specifically, the types of data we collect and how we use it, as well as how we share, safeguard, and dispose of collected information.

Please contact NHICPrivacy@hp.com.