DME MAC Jurisdiction A Resource

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

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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 website at:
http://www.medicarenhic.com/dme/

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2016 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List (MM9481) (GEN)

MLN Matters® Number: MM9481
Related CR Release Date: December 31, 2015
Related CR Transmittal #: R3432CP
Related Change Request (CR) #: CR9481
Effective Date: January 1, 2016
Implementation Date: February 1, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9481 notifies suppliers that the spreadsheet containing an updated jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the "*Medicare Claims Processing Manual*" are reflected in the recurring update notification. The spreadsheet for the 2016 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html and is also attached to CR9481.

Additional Information

The official instruction, CR9481, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3432CP.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.

Healthcare Provider Taxonomy Codes (HPTCs) April 2016 Code Set Update (MM9461) (GEN)

MLN Matters® Number: MM9461
Related CR Release Date: February 19, 2016
Related CR Transmittal #: R3467CP
Related Change Request (CR) #: CR 9461
Effective Date: April 1, 2016
Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9461 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.

CR9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

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

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

Additional Information

The official instruction, CR9461, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3467CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

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

MLN Matters® Number: MM9231 Revised
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

Note: *This article was revised on December 9, 2015, to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim, regardless of the date of service, when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification. All other information is unchanged.*

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 9231updates 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 for Claims Processed on or after January 1, 2016 (Regardless of Service Date)

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.

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.

Document History

Date of Change	Description
December 9, 2015	Revised to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim regardless of the date of service when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification

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New Non-Physician Specialty Code for Dentist (MM9355) (SPE)

MLN Matters® Number: MM9355
Related CR Release Date: January 29, 2016
Related CR Transmittal #: R3447CP and R262FM
Related Change Request (CR) #: CR 9355
Effective Date: July 1, 2016
Implementation Date: July 5, 2016

Provider Types Affected

This MLN Matters® Article is intended for Dentists and certain suppliers submitting claims to Medicare Administrative Contractors (MACs) for dental services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9355 announces that the Centers for Medicare & Medicaid Services (CMS) has created a new non-physician specialty code (C5) for Dentist.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application ((CMS-855B, CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Non-physician practitioners are assigned a Medicare specialty code when they enroll.

The specialty code becomes associated with the claims that the physician or non-physician practitioner submits, and describes the specific/unique types of medicine that they (and certain other suppliers) practice. CMS uses specialty codes for programmatic and claims processing purposes.

Additional Information

The official instruction, CR9355, issued to your MAC regarding this change consists of two transmittals. The first revises the "*Medicare Claims Processing Manual*" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3447CP.pdf on the CMS website. The second transmittal updates the "*Medicare Financial Management Manual*" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R262FM.pdf on the CMS website.
If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Implementation of Fingerprint-Based Background Checks (SE1417) (GEN)

MLN Matters® Number: SE1417 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 January 27, 2016, to update language in the article and to emphasize affected providers and suppliers in the Caution Section.*

Provider Types Affected

This MLN Matters® Special Edition article is intended for all providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 6401 of the *Affordable Care Act*.

What You Need to Know

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. **A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a high risk provider or supplier.** Note that the high level of risk category applies to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers or Home Health Agencies (HHA). It also applies to providers and suppliers who have been elevated to the high risk category. CMS may adjust a particular provider or supplier's screening level from "limited" to "high" or "moderate" to "high" if any of the following occur:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

What You Need to Do

See the Background and Additional Information Sections of this article for further details.

Background

As part of the enhanced enrollment screening provisions contained in the *Affordable Care Act* (see https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf), the Centers for Medicare & Medicaid Services (CMS) implemented fingerprint-based background checks. The fingerprint-based background checks will be used to detect bad actors who are attempting to enroll in the Medicare program and to remove those currently enrolled. Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a provider or supplier. Fingerprint- based background checks are also required for any provider or supplier who has been elevated to the high risk category for any of the following reasons:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
- Has been subject to any final adverse action, in the previous 10 years;

- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

Please refer to 42 CFR 424.518(c)(3) at http://www.ecfr.gov/cgi-bin/text-idx?SID=a39ae0804106965d82b5ae6413ba550e&node=42:3.0.1.1.11.12.5.11&rgn=div8 on the Internet and the "*Medicare Program Integrity Manual*" (Chapter 15 (Medicare Enrollment), Section 15.19.2.1C (Screening Categories-Background-High)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf on the CMS website.

Note: *The fingerprint-based background checks will be applied to providers and suppliers in the high level of risk category, which includes newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, Home Health Agencies (HHA) and providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.*

The fingerprint-based background check implementation has been phased in beginning in 2014.

Affected providers and suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a notification letter to the affected providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The notification letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare. Generally, an individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed.

The relevant individuals will have 30 days from the date of the notification letter to be fingerprinted. If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The notification letter will identify contact information for the Fingerprint-Based Background Check Contractor (FBBC). The relevant individual(s) are required to contact the FBBC prior to being fingerprinted to ensure the fingerprints are accurately submitted to the Federal Bureau of Investigation (FBI) and results are properly returned to CMS. Providers/suppliers may contact the FBBC by telephone or by accessing the FBBC's website. Contact information for the FBBC will be provided in the notification letter received from the MAC. Once contacted, the FBBC will provide at least three fingerprint locations convenient to the relevant individual's location. One of these locations will be a local, state, or federal law enforcement facility.

The relevant individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken, and the cost may vary depending on location. **Once an individual has submitted his/her fingerprints, if that individual is subsequently required to undergo a fingerprint-based background check in accordance with 42 CFR 424.518(c), CMS will, to the extent possible, rerun the fingerprint-based background check rather than requiring resubmission of fingerprints.** You can review 42 CFR 424.518(c) at http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.11&rgn=div8 on the Internet.

Fingerprinting can be completed on the FD-258 form or electronically at certain locations. CMS strongly encourages all required applicants to provide electronic fingerprints, but CMS will accept the FD-258 card instead. If the FD-258 form is submitted, the FBBC will convert the paper form to electronic submission to the FBI. You can review the FD-258 form at: https://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1 on the Internet.

Once the fingerprint process is complete, the fingerprints will be forwarded to the FBI for processing. Within 24 hours of receipt, the FBI will compile the background history based on the fingerprints and will share the results with the FBBC. CMS, through the FBBC, will assess the law enforcement data provided for the fingerprinted individuals. The FBBC will review each record and provide a fitness recommendation to CMS. CMS will assess the recommendation and make a final determination.
All fingerprint data will be stored according to:

- Federal requirements;
- FBI Security and Management Control Outsourcing Standards for Channelers and Non-Channelers; and
- The FBI Criminal Justice Information Services (CJIS) Security Policy.

The FBBC will maintain *Federal Information Systems Management Act* (FISMA) certification and comply with the FBI (CJIS) Security Policy. All data will be secured in accordance with the *Privacy Act of 1974* and the FBI CJIS Security Policy.

CMS will rely on existing authority to deny enrollment applications and revoke existing Medicare billing privileges per 42 CFR §424.530(a) and §424.535(a) (http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.15&rgn=div8) if an individual who maintains a 5 percent or greater direct or indirect ownership interest in a provider or supplier has submitted an enrollment application that contains false or misleading information. Providers or suppliers will be notified by CMS if the assessment of the fingerprint based background check results in the denial of its enrollment application or revocation of its existing Medicare billing privileges.

Additional Information

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

Document History

Date of Change	Description
January 27, 2016	The article was revised to update language in the article and to emphasize affected providers and suppliers in the Caution Section.

Intravenous Immune Globulin (IVIG) Demonstration: Payment Update for 2016 (MM9254) (SPE)

MLN Matters® Number: MM9254
Related CR Release Date: December 4, 2015
Related CR Transmittal #: R130DEMO
Related Change Request (CR) #: CR 9254
Effective Date: January 1, 2016
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 Q2052 (services, supplies, and accessories used in the home under the Medicare IVIG Demonstration).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9254 to specify the payment rate for 2016 for Q2052. That 2016 payment rate is $336.05. Make sure your billing staffs are aware of the update.

Background

The *Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012* authorizes a three year demonstration under Part B of Title XVIII of *the Social Security Act* to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD). CRs 8599 and 8724 specified the requirements for implementing this demonstration. CR 8599 specified the payment rate for the administration of IVIG under the demonstration for 2014 and CR 8599 provided for annual updates to this rate. CR8599 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R115DEMO.pdf on the CMS website.

Additional Information

The official instruction, CR 9254, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R130DEMO.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?

Manual Update to Pub. 100-04, Chapter 20, to Include Used Rental Equipment (MM9488) (GEN)

MLN Matters® Number: MM9488
Related CR Release Date: January 29, 2016
Related CR Transmittal #: R3443CP
Related Change Request (CR) #: CR9488
Effective Date: July 1, 2016
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9488 notifies providers and suppliers that effective July 1, 2016, when a beneficiary elects to purchase previously rented Inexpensive and Routinely Purchased (IRP) DME, and the service has a UE (purchase of used equipment) modifier, the Medicare allowed amount for used purchased equipment will be calculated at the lower of the purchase fee schedule amount (UE) minus previous paid rental amounts or the actual charge for the used purchased equipment.

This is a new policy for the Centers for Medicare and Medicaid Services (CMS) therefore; the purpose of this CR9488 is to add manual subsection, 30.1.1.2 "*Used Rental Equipment*" to Chapter 20 of Pub. 100-4, the "*Medicare Claims Processing Manual*."

Background

The payment rules for capped rental DME and IRP DME are laid out in Section1834 (a) (7) and (2) of the *Social Security Act*. When determining the Medicare payment amount in instances where the beneficiary elects to purchase previously rented IRP DME, the Medicare allowed amount should take into consideration payment made for any previous rentals when determining the allowed amount for the purchased equipment. Specifically, when a beneficiary elects to purchase used equipment under the IRP payment category after having made previous capped rental monthly payments, the Medicare allowed amount for the used purchased equipment should be capped at the lower of:

- The purchase used (UE) fee schedule amount minus previous rental payments; or
- The actual charge for the used equipment.

Additional Information

The official instruction, CR9488 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3443CP.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.

Payment Clarification for the Purchase of Used Inexpensive and Routinely Purchased Durable Medical Equipment (DME) when Previously Rented (MM9491) (GEN)

MLN Matters® Number: MM9491
Related CR Release Date: January 29, 2016
Related CR Transmittal #: R1601OTN
Related Change Request (CR) #: CR 9491
Effective Date: July 1, 2016
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9491, from which this article is taken, provides clarification on the payment for the purchase of used inexpensive and routinely purchased Durable Medical Equipment (DME) in cases where there were previous rental payments.

Background

Section 1834(a), (h), and (i) of the *Social Security Act* (the Act) require payment on a fee schedule basis for certain Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings; and Section 1834(a)(7) and (2) provides the payment rules for capped rental DME and Inexpensive and Routinely Purchased (IRP) DME. (You can find Section 1834 of the Act at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet).

In determining the Medicare payment amount when the beneficiary elects to purchase previously rented IRP DME, the Medicare allowed amount should take into consideration payment made for any previous rentals.

CR9491 provides that (effective July 1, 2016) when a beneficiary elects to purchase previously rented IRP DME and the service has a UE (purchase of used equipment) modifier, the Medicare allowed amount for used purchased equipment will be calculated at the lower of the purchase fee schedule amount (UE) minus previous paid rental amounts or the actual charge for the used purchased equipment.

Specifically, in these cases, you should deduct the previous paid rental amounts or the actual charge for the used purchase equipment from the Medicare allowed amount for used purchase equipment.

Additional Information

The official instruction, CR9491 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1601OTN.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.

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program (SE1128) (GEN)

MLN Matters® Number: SE1128 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 February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3. All other information is the same.*

Provider Types Affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare Advantage plan.

What you Need to Know

Impact to You

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing** (such charges are known as "balance billing"). QMB is a Medicare Savings Program that exempts Medicare beneficiaries from Medicare cost-sharing liability.

What You Need to Know

The QMB program is a State Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost-sharing, regardless of whether the State

reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers --not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the federal balance billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a Medicare Advantage provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments. This practice is known as "balance billing."

Balance Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the *Balanced Budget Act of 1997*. (Please note, this section of the Act is available at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm on the Internet.)

QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, as permitted by federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the *Social Security Act*.)

Inappropriate Balance Billing Persists

Despite federal law, erroneous balance billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. See Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015 at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf on the CMS website.

Important Clarifications Concerning QMB Balance Billing Law

Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First, know that all original Medicare and MA providers - not only those that accept Medicaid-- must abide by the balance billing prohibitions.

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different State than the State in which care is rendered.
Finally, note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the "*State Medicaid Manual*," which is no longer in effect.

Ways to Improve Processes Related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and Medicare Advantage plans if applicable), can promote compliance with QMB balance billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients. Find out what cards are issued to QMB individuals so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. If you are a Medicare Advantage provider contact the plan to determine how to identify the plan's QMB enrollees.
2. Discern what billing processes apply to seek reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare

claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.
- Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

3. Make sure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

QMB Eligibility and Benefits

Dual Eligibility	Eligibility Criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	• Resources cannot exceed $7,280 for a single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents. • Income cannot exceed 100% of the Federal Poverty Level (FPL) +$20 ($1,001/month - Individual $1,348/month - Couple in 2015). **Note: These guidelines are a federal floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards.**	Medicaid Pays Medicare Part A and B premiums, deductibles, co-insurance and co-pays to the extent required by the State Medicaid Plan. • Exempts beneficiaries from Medicare cost-sharing charges • The State may choose to pay the Medicare Advantage (Part C) premium.
QMB Plus	• Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage	Provides all benefits available to QMBs, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient

Additional Information

For more information about dual eligible categories and benefits, please visit http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf on the Internet. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled "*Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)*," (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf) which is available on the CMS website. For general Medicaid information, please visit the Medicaid webpage at http://www.medicaid.gov/index.html on the CMS website.

Document History

Date of Change	Description
February 4, 2016	The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.
March 28, 2014	The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to Benefits Coordination & Recovery Center (BCRC).

Provider Enrollment Revalidation - Cycle 2 (SE1605) (GEN)

MLN Matters® Number: SE1605
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 Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Impact to You

Section 6401 (a) of the *Affordable Care Act* established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

What You Need to Know

Special Note: *The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.*

What You Need to Do

1. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
    - Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
    - Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html;
    - If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and
    - Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

Section 6401 (a) of the *Affordable Care Act* established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at http://go.cms.gov/MedicareRevalidation and will include **all** enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at http://go.cms.gov/MedicareRevalidation on the CMS website.

  IMPORTANT: *The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.*

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).

- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

  Revalidation notices sent via email will indicate "**URGENT: Medicare Provider Enrollment Revalidation Request**" in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

  NOTE: *Providers/suppliers who are within 2 months of their listed due dates on http://go.cms.gov/MedicareRevalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.*

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on http://go.cms.gov/MedicareRevalidation to determine their provider/supplier's revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier's due date will be *returned.*

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (To Be Determined). This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
- If your intention is to submit a change to your provider enrollment record, you must submit a '*change of information*' application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier's enrollment record includes information such as the provider's individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided).This means the

provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html on the CMS website.

Getting Access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC's at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at EUSSupport@cgi.com

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

NOTE: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will **not** be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider's liability.

Revalidation Timeline and Example

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2016
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2016
MAC sends email/letter notification	75 - 90 days prior to due date	July 2 - 17, 2016
MAC sends letter for undeliverable emails	75 - 90 days prior to due date	July 2 - 17, 2016
Revalidation due date		**September 30, 2016**
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2016
Deactivate	60 - 75 days after due date	November 29 - December 14, 2016

Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $554.00 for Calendar Year (CY) 2016. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2016 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

SUMMARY:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on http://go.cms.gov/MedicareRevalidation for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire **Medicare enrollment record, including all reassignment and practice locations**. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges. If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information

To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.

A sample revalidation letter is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf on the CMS website.

A revalidation checklist is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html on the CMS website.

For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnrolI_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf on the CMS website.

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2016 (MM9477) (GEN)

MLN Matters® Number: MM9477
Related CR Release Date: December 18, 2015
Related CR Transmittal #: R3424CP
Related Change Request (CR) #: CR9477
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9477 provides the DMEPOS CBP April 2016 quarterly update. CR9477 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 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.

Additional Information

The official instruction, CR 9477 issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3424CP.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.

The DMEPOS Competitive Bidding Program site includes information on all rounds of the CBP, including product categories and single payment amounts for the Round One Re-compete, Round Two, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.

The MLN Catalog of Products (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf) contains several products that describe the various aspects of the DMEPOS program.

Reclassification of Certain Durable Medical Equipment HCPCS Codes Included in Competitive Bidding Programs (CBP) from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category (MM8822) (GEN)

MLN Matters® Number: MM8822
Related CR Release Date: February 19, 2016

Related CR Transmittal #: R1626OTN

Related Change Request (CR) #: CR 8822
Effective Date: July 1, 2016 - except in Round 1 Re-compete CBP areas where effective date is January 1, 2017
Implementation Date: July 5, 2016 - except for A/B and HHH MACs where implementation is 10/3/2016

Provider Types Affected

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

What You Need to Know

Change request (CR)8822 provides instructions for the upcoming reclassification of certain Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes, that are included in Round 2 and Round 1 Re-compete DMEPOS CBPs, from the inexpensive and routinely purchased DME payment category to the capped rental DME payment category.

CR 8822 follows CR 8566, Rescind and Replace of CR 8409: Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category, which was released on March 25, 2014. You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8566.pdf on the CMS website. Make sure your billing staffs are aware of these changes.

Background

Medicare defines routinely purchased DME (set forth at 42 CFR §414.220(a)(2)) as equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989 (that is, new codes added to the HCPCS after 1989 for items costing more than $150) showed inconsistencies in applying the definition.

As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. Also in that rule, the Centers for Medicare & Medicaid Services (CMS) established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 - K0864), will be paid under the associated lump sum purchase option set forth at 42

CFR § 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the *Social Security Act*. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

In order to align the payment category with the required regulatory definition, the HCPCS codes in the table below will reclassify to the capped rental payment category effective:

- July 1, 2016: Items furnished in all areas except the nine Round 1 Re-compete CBAs; and
- January 1, 2017: Items furnished in the nine Round 1 Re-compete CBAs.

HCPCS Codes for Items Reclassified to Capped Rental DME Category

HCPCS Code	Description
E0197	Support Surfaces
E0140, E0149	Walkers
E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070	Wheelchairs Options/Accessories
E0955	Wheelchair Seating

Further Details from CR8822:

1. In Round 1 Re-compete CBAs, payment for HCPCS codes shown in the above table will be made under the inexpensive and routinely purchased (IN) payment category for dates of service July 1, 2016 through December 31, 2016. Your MAC will recognize that the capped payment category requires payment of 10 percent of the purchase price for the first three months and 7.5 percent for each of the remaining rental months 4 through 13. You should also be aware that payment amounts will be based on the lower of the supplier's actual charge and the fee schedule amount. Your MAC will return as unprocessable claims for the inexpensive and routinely purchased codes described above that are billed with the KH, KI and KJ modifiers. Such unprocessable claims will be returned with Claim Adjustment Reason Code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), Remittance Advice Remark Code (RARC) N519 (Invalid combination of HCPCS modifiers) and Group Code CO (Contractual Obligation).
2. Effective for claims with dates of service on or after July 1, 2016, for items furnished in Round 2 CBAs, your MAC will cease any IN category rental payments for the codes in the above table and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (July 1, 2016)).
3. Effective for claims with dates of service on or after January 1, 2017, for items furnished in Round 1 Re-compete CBAs, your MAC will cease any IN rental payments for these codes, and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (January 1, 2017)).
4. Effective July 1, 2016, in all areas except the nine Round 1 CBAs, your MACs will process and pay claims for wheelchair base codes K0835 - K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.
5. Effective January 1, 2017 in all areas including the Round 1 Re-compete CBAs, your MACs will process and pay claims for the codes K0835 - K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.
6. When Home Health/Hospice providers (HHHs) bill codes E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070 and E0955 for services outside a competitive bid area on or after July 1, 2016, payment will be made on a capped rental basis.
7. When HHHs bill E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 for services outside a competitive bid area on or after July 1, 2016, MACs will process such claims on a lump sum purchase basis, where applicable, when used with a complex rehabilitative wheelchair base (K0835-K0864).

Additional Information

The official instruction, CR 8822 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1626OTN.pdf on the CMS website.

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

April 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9536) (DRU)

MLN Matters® Number: MM9536
Related CR Release Date: February 4, 2016
Related CR Transmittal #: R3450CP
Related Change Request (CR) #: CR 9536
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

Provider Action Needed

Medicare will use the April 2016 quarterly Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2016, with dates of services from April 1, 2016, through June 30, 2016.

Change Request (CR) 9536 instructs MACs to implement the April 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2016, October 2015, July 2015, and April 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in the "*Medicare Claims Processing Manual*," Chapter 4, Section 50 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf).

The following table shows how the files will be applied.

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

Additional Information

The official instruction, CR9536 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3450CP.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.

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

April Quarterly Update for 2016 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM9554) (GEN)

MLN Matters® Number: MM9554
Related CR Release Date: February 26, 2016
Related CR Transmittal #: R3472CP
Related Change Request (CR) #: CR 9554
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9554 provides the April quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Because there are no updates from the previous quarter (January through March 2016), an April update to the 2016 DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files is not scheduled for release. However, an April 2016 DMEPOS Rural ZIP code file containing Quarter Two, 2016 rural ZIP Code changes is being provided to the MACs.

The *April 2016 DMEPOS Rural ZIP code Public Use File (PUF)* (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/), containing the rural ZIP codes effective for Quarter 2, 2016, will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above file.

Background

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

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

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. CMS issued a final rule on November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs.

CMS issued a final rule on November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (http://www.dmecompetitivebid.com).

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments. To apply the adjusted fees rural payment rule for areas within the contiguous United States, the DMEPOS and PEN fee schedule files have been updated, effective January 1, 2016, to include rural payment amounts for certain HCPCS codes.

Beginning January 1, 2016, the ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the competitive bidding program. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file.

The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary. Program instructions on these changes are available in MLN® Matters 9431 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf) entitled "*Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule*" based on Transmittal 3416, Change Request (CR) 9431, dated November 23, 2015.

Additional Information

The official instruction, CR9554, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3472CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Fee Schedule Updates (GEN)

The 2016 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC JA) Website, http://www.medicarenhic.com/dme/dmfees.aspx. This quarter the following notices have been posted:

- 1st Quarter 2016 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2016 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2016 Oral Anticancer Drug Fees
- 4th Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File was revised
- 1st Quarter 2015 Average Sales Price Medicare Part B Drug Pricing File was revised

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

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

MLN Connects® Provider eNews (GEN)

MLN Connects® Provider eNews for December 10, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-12-10-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-12-10-eNews.pdf

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call - Register Now

MLN Connects Videos

- ICD-10 Post-Implementation: Coding Basics Revisited

Announcements

- CMS Releases 2014 National Health Expenditures
- ICD-10 Specialty Resources Guide
- EHR Incentive Programs: 2015 Program Requirement Resources
- Hospital Compare Website Refresh
- New ST PEPPER Available

- Hospice Item Set Record Submissions: CASPER Reports Available
- Long-Term Care Facilities: Mandatory Electronic Staffing Data Submission Begins in 2016
- 2016 Value Modifier Informal Review Deadline December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline December 16
- Corrections Made to 2016 DMEPOS Fee Schedules

Medicare Learning Network® Publications

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course - Revised
- Health Care Professional Frequently Used Web Pages Educational Tool - Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet - Revised
- Reading the Institutional Remittance Advice Fact Sheet - Revised

MLN Connects® Provider eNews for December 17, 2015

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-12-17-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-12-17-eNews.pdf

Editor's Note: *Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 7, 2016.*

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call - Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session - Registration Now Open
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call - Registration Opening Soon
- New Audio Recording and Transcript Available

Announcements

- CMS Expands Quality Data on Physician Compare and Hospital Compare
- CMS Hospital-Acquired Conditions Reduction Program: FY 2016 Results
- Corrections Made to 2016 DMEPOS Fee Schedules

Claims, Pricers, and Codes

- January 2016 Average Sales Price Files Available
- FY 2016 Inpatient PPS PC Pricer Update Available
- Claims Processing Issue for Reference Laboratory and Anti-markup Payment Limitation Services Resolved

Medicare Learning Network® Videos

- CMS Provider Minute: Hospital Discharge Day Management Services Video - New
- What is the HIPAA Privacy Rule? Tips to Protect Your Patients' Privacy Video - New

Medicare Learning Network Publications

- Reading a Professional Remittance Advice Booklet - Revised
- New MLN Provider Compliance Fast Fact

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

MLN Connects® Provider eNews for January 07, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-01-07-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-01-07-eNews.pdf

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call - Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session - Register Now
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call - Register Now
- New Audio Recordings and Transcripts Available
- Stay Informed about Medicare Program Changes

Other CMS Events

- Comparative Billing Report on Home E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- FY 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data MLN Matters® Article - Released
- Remittance Advice Resources and FAQs Fact Sheet - New
- Medicare Overpayments Fact Sheet - Revised
- Medicare Vision Services Fact Sheet - Revised
- Screening, Brief Intervention, and Referral to Treatment Services Fact Sheet - Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet - Revised
- Certificate of Medical Necessity Web-Based Training Course - Revised
- New Educational Web Guides Fast Fact

Announcements

- Medicare FFS Utilization and Payment Data Available for HHAs
- CMS Finalizes Rule Creating Prior Authorization Process for Certain DMEPOS Items
- CMS Quality Measure Development Plan
- Improving the Submission of Quality Data to CMS Quality Reporting Programs
- Pilot Project to Test Improving Patients' Health by Addressing Their Social Needs
- EHR Incentive Programs: 2015 Program Year Attestation Begins January 4
- PQRS: Submission Timeframes for 2015 Data
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- IRF Data Submission Deadline Extended to February 15
- LTCH Data Submission Deadline Extended to February 15
- LTCH QRP: FAQs and Provider Training Materials Available
- Hospice Item Set Timeliness Compliance Threshold Fact Sheet Available
- Improving the Documentation of Chiropractic Services Video
- Reporting the Diabetes: Hemoglobin A1c Measure for Program Year 2015
- CMS to Release a Comparative Billing Report on Domiciliary E/M Services in January
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2016
- Continue Seasonal Influenza Vaccination through January and Beyond

Claims, Pricers, and Codes

- Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 MPFS
- Provider Enrollment Application Fee Amount for CY 2016
- Clarification for Coding Relating to Cologuard
- January 2016 OPPS Pricer File Available

- January 2016 FQHC Pricer Files Available
- Transcatheter Mitral Valve Repair Claims Editing Incorrectly
- Pharmacogenomic Testing for Warfarin Responsiveness Claims Editing Incorrectly
- Adjustments to Correct Home Health Claim Payments

MLN Connects® Provider eNews for January 14, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-01-14-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-01-14-eNews.pdf

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call - Last Chance to Register
- Collecting Data on Global Surgery as Required by MACRA Listening Session - Last Chance to Register
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call - Register Now

Medicare Learning Network® Publications and Multimedia

- Introduction to the IMPACT Act of 2014 Video - New
- Preventive Services Poster - New
- Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training - New
- Medicare Parts C and D General Compliance Training Web-Based Training - New
- Combatting Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training - New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool - New
- Hospice Payment System Fact Sheet - Revised
- ICD-10 Post-Implementation: Coding Basics Revisited Video - Reminder

Announcements

- Accountable Care Organization Initiatives Announced to Improve Health System Care Delivery
- Home Health Compare: Deadline to have Data Suppressed is January 25
- CMS to Release a Comparative Billing Report on Electrodiagnostic Testing in February
- Revised Two-Midnight Rule Guidelines
- PQRS Web-Based Measure Search Tool
- January is Cervical Health Awareness Month

MLN Connects® Provider eNews for January 21, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-01-21-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-01-21-eNews.pdf

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call - Register Now

Other CMS Events

- Comparative Billing Report on Domiciliary E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- PECOS FAQs Fact Sheet - Revised
- The Medicare Home Health Benefit Booklet - Revised

Announcements

- CMS Updates Open Payments Data and Improves Website
- Open Payments System Downtime from January 21 through 26
- LTCH Quality Reporting Program Data Submission Deadline: February 15
- IRF Quality Reporting Program Data Submission Deadline: February 15
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- LTCH and IRF Dry Run Readmission Reports Available
- Update to IRF-PAI Training Manual V1.4
- Read More about What is Next for the EHR Incentive Programs
- Help Protect the Vision of Your Medicare Patients

Claims, Pricers, and Codes

- January 2016 OPPS Pricer File Update

MLN Connects® Provider eNews for January 28, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-01-28-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-01-28-eNews.pdf

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call - Last Chance to Register

Other CMS Events

- Special Open Door Forum: Understanding the IMPACT Act
- LTCH Quality Reporting Program Webinar
- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- CMS Provider Minute: Duplicate Professional Claims Video - New
- Medicare Advance Beneficiary Notices Booklet - Revised
- Skilled Nursing Facility Billing Reference Fact Sheet - Revised
- Suite of Products & Resources for Billers & Coders Educational Tool - Revised
- Suite of Products & Resources for Compliance Officers Educational Tool - Revised
- Suite of Products & Resources for Educators & Students Educational Tool - Revised
- Suite of Products & Resources for Inpatient Hospitals Educational Tool - Revised
- Updated MLN Matters® Search Indices
- New Educational Web Guides Fast Fact

Announcements

- CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
- PQRS: Submission Timeframes for 2015 Data
- Comment Period for IMPACT Act Measures Extended to January 29
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- CMS to Release a Comparative Billing Report on Modifier 25: Internal Medicine in February
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Prior Authorization for Certain DMEPOS Items: FAQs on the Final Rule
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Payment for Group 3 Power Wheelchair Cushions and Accessories
- Changes to the Medicare EHR Incentive Program Hardship Exception Process
- Testing QRDA l Release 2 and QRDA III Release 1 Files

Claims, Pricers, and Codes

- New Drug Testing Laboratory Codes Editing Incorrectly

MLN Connects® Provider eNews for February 04, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-02-04-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-02-04-eNews.pdf

MLN Connects® Events

- New Audio Recordings and Transcripts Available

Other CMS Events

- Medicare Quality Reporting Programs Webinar: What Eligible Providers Need to Know in 2016

Medicare Learning Network® Publications and Multimedia

- Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters® Article - Revised
- Implementation of Fingerprint-Based Background Checks MLN Matters Article - Revised
- The Medicare Home Health Benefit Web-Based Training Course - Revised
- Remittance Advice Information: An Overview Fact Sheet - Revised
- Medicare Advance Beneficiary Notices Booklet - Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet - Revised

Announcements

- CMS Announces Proposed Improvements to Medicare Shared Savings Program
- CMS Releases Home Health Patient Experience of Care Star Ratings
- New Proposal to Give Providers and Employers Access to Information to Drive Quality and Patient Care Improvement
- Comment Period for IMPACT Act Measures Extended to February 5
- Comment Period for RFI on Reporting of Quality Measures Extended to February 16
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- Register in Open Payments System to Review and Dispute 2015 Data
- 2015 PQRS Data: Submission Deadlines
- Applying for an EHR Hardship Exception: FAQs
- Temporary Moratoria Extended on Enrollment of New Home Health Agencies and Part B Ambulance Suppliers
- Stop Hepatitis C Virus Transmission in Patients Undergoing Hemodialysis
- Flu Season Begins: Severe Influenza Illness Reported
- February is American Heart Month

MLN Connects® Provider eNews for February 11, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-02-11-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-02-11-eNews.pdf

MLN Connects® Events

- Provider Enrollment Revalidation Call - Registration Now Open

Other CMS Events

- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- Telehealth Services Fact Sheet - Revised
- Ambulance Fee Schedule Fact Sheet - Revised
- Reading a Professional Remittance Advice Booklet - Reminder

Announcements

- 39 Million Medicare Beneficiaries Utilized Free Preventive Services in 2015
- Nursing Facility Initiative Annual Report
- EHR Incentive Programs: Clinical Decision Support Interventions
- EHR Incentive Programs: New Tipsheet on Eligibility for Broadband Access Exclusions
- Implementation of Section 2 of the Patient Access and Medicare Protection Act
- Influenza Activity Continues

Claims, Pricers, and Codes

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® Provider eNews for February 18, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-02-18-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-02-18-eNews.pdf

MLN Connects® Events

- Provider Enrollment Revalidation Call - Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Electrodiagnostic Testing Webinar

Medicare Learning Network® Publications and Multimedia

- Medicare Basics Commonly Used Acronyms Educational Tool - Revised
- PECOS Technical Assistance Contact Information Fact Sheet - Reminder
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet - Reminder

Announcements

- Medicare Reporting and Returning of Self-Identified Overpayments
- IMPACT Act Technical Expert Panel Call for Nominations through February 26
- Submitting Comments on MACRA Episode Groups: Deadline Extended to March 1
- 2015 PQRS EHR Submission Deadline Extended to March 11
- EHR Incentive Programs Attestation Deadline Extended to March 11
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- EHR Incentive Programs: Updated FAQs Available

MLN Connects® Provider eNews for February 25, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-02-25-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-02-25-Enews.pdf

MLN Connects® Events

- Provider Enrollment Revalidation Call - Last Chance to Register
- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology - New

Medicare Learning Network® Publications and Multimedia

- Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs, and CAHs MLN Matters® Article - Released
- Ambulatory Surgical Center Fee Schedule Fact Sheet - Revised
- New Educational Web Guides Fast Fact

Announcements

- Alignment and Simplification of Quality Measures
- CMS Publishes Medicare FFS Provider and Supplier Lists
- Strengthening Provider and Supplier Enrollment Screening
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Quality of Patient Care Star Ratings TEP: Nomination Period Open through March 18
- EHR Hardship Exception Application: New FAQ

MLN Connects® Provider eNews for March 03, 2016

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-03-03-eNews.html

View this edition as a PDF
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2016-03-03-eNews.pdf

MLN Connects® Events

- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology-Reminder

Medicare Learning Network® Publications and Multimedia

- Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article - New
- CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act Video - New
- CMS Provider Minute: Multiple Same Day Surgeries and Modifier 51 Video - New
- Home Health Prospective Payment System Booklet - Revised
- Suite of Products & Resources for Rural Health Providers Educational Tool - Revised
- DMEPOS Quality Standards Booklet - Reminder

Announcements

- Major Commitments from Healthcare Industry to Make Electronic Health Records Work Better
- Program Integrity Enhancements to the Provider Enrollment Process
- CMS to Release a Comparative Billing Report on Non-invasive Vascular Studies in March
- EHR Incentive Program Hardship Application Deadline Extended to July 1
- EHR Incentive Programs: FAQs on Public Health Reporting Requirements
- ICD-10 Next Steps Toolkit
- Antipsychotic Drug use in Nursing Homes: Trend Update
- "Savor the Flavor of Eating Right" During National Nutrition Month® and Beyond

Claims, Pricers, and Codes

- Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program - "Sequestration"

DME MAC JA Local Coverage Determinations (GEN)

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

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

LCD and Policy Article Revisions Summary for December 17, 2015 (GEN)

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

Nebulizers

LCD

Revision Effective Date: 01/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Deleted: HCPCS Code A7011 from Accessories tables

HCPCS CODES:

Deleted: HCPCS Code A7011

Added: HCPCS Code J7999

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:

Group 5 Codes:

Deleted: Code A7011 from the List of HCPCS codes

Group 7 Codes:

Added: ICD-10 Code E84.0 to Group 7 for J7608

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

MISCELLANEOUS:

Deleted: Duplicative information about what is required on orders

Updated: HCPCS Code Q9977 cross-walked to J7999

Added: Standard product identification requirements for NOC codes

Policy Article

Revision Effective Date: 01/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Start date verbiage from Prescription Requirements (Effective 11/05/2015)

CODING GUIDELINES:

Updated: HCPCS Code Q9977 cross-walked to J7999

Pneumatic Compression Devices

LCD

Revision Effective Date: 12/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Trial requirements to reference "no significant improvement" rather than "no further improvement" for lymphedema, CVI, and for lymphedema extending on to the chest, trunk and/or abdomen

Removed: Word "Any" from trial requirements for lymphedema of the chest, trunk and/or abdomen

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

Policy Article

Revision Effective Date: 12/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Start date verbiage from Prescription Requirements (Effective 11/05/2015)

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

LCD and Policy Article Revisions Summary for March 03, 2016 (GEN)

Outlined below are the principal changes to a DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Ankle-Foot/Knee-Ankle-Foot Orthosis, Bowel Management Devices, External Infusion Pumps, Immunosuppressive Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics), Parenteral Nutrition, Respiratory Assist Devices, Wheelchair Options/Accessories. Please review the entire LCD and related PA for complete information.

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 01/01/2016:

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: L4361 “clerical correction”

HCPCS CODES:

Revised: L1902 and L1904 long narrative description

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)

Moved: Repair/Replacement verbiage to correct location

Updated: Miscellaneous section when billing L2999

Policy Article

Revision Effective Date: 01/01/2016

CODING GUIDELINES:

Added: L4361 “clerical correction”

Bowel Management Devices

LCD

Revision Effective Date: 01/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Replaced: Miscellaneous HCPCS Code A4335 with new code A4337

HCPCS CODES:

Added: HCPCS Code A4337

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

Policy Article

Revision Effective Date: 01/01/2016

CODING GUIDELINES:

Replaced: Miscellaneous HCPCS Code A4335 with new code A4337

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: HCPCS CODE J1575 to Subcutaneous immune globulin coverage
Added: HCPCS CODE J7340 to Levodopa-Carbidopa coverage
Added: HCPCS CODE J9039 to Blinatumomab coverage
Updated: HCPCS Code Q9977 crosswalked to J7999
HCPCS CODES:
Group 3 Codes:
Added: HCPCS Code J1575, J7340, J9039 (previously J7799)
Deleted: HCPCS Code Q9977
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Group 3 Codes:
Added: ICD-10 Code D83.1 to Group 3 Codes
Group 3 Paragraph:
Added: HCPCS Code J1575
Group 4 Paragraph:
Added: HCPCS Code J7340
Group 5 Paragraph:
Added: HCPCS Code J9039
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)

Policy Article
Revision Effective Date: 01/01/2016
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)
CODING GUIDELINES:
Updated: HCPCS Code Q9977 cross-walked to J7999
Added: J1575, J7340, J9039 (previously J7799)
Updated: Billing instructions, by HCPCS code, based on dates of service

Immunosuppressive Drugs

LCD
Revision Effective Date: 01/01/2016
HCPCS CODES:
Added: J7503 and J7512
Updated: J7508 narrative
Deleted: J7506
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)

Policy Article
Revision Effective Dates: 01/01/2016
CODING GUIDELINES:
Removed: J7506 from billing example, replaced with J7510

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD
Revision Effective Date: 01/01/2016
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Updated: 3-drug regimen billing instructions
HCPCS CODES:
Added: HCPCS code J8655
Deleted: HCPCS code Q9978
DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: J8655 to modifier billing instructions

Added: End date for HCPCS code Q9975

Added: Q0181 for billing rolapitant on or after 09/02/2015

KX, GA AND GZ MODIFIERS:

Added: Rolapitant (Q0181) to guidelines

Added: J8655 to guidelines

Policy Article

Revision Effective Date: 01/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Covered 3-drug combination regimen

CODING GUIDELINES:

Added: J8655

Added: End date of 12/31/2015 for Q9978

Added: Q0181 for billing rolapitant effective on or after 09/02/2015

Parenteral Nutrition

LCD

Revision Effective Date: 01/01/2016

HCPCS CODES:

Group 1 codes:

Updated: HCPCS Code B5000, B5100, B5200 narrative description

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

Policy Article

Removed: Effective Date from Policy Article title

Respiratory Assist Devices

LCD

Revision Effective Date: 01/01/2016

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Replaced: HCPCS Codes E0450, E0460-E0464 with new HCPCS Codes E0465, E0466

DOCUMENTATION REQUIREMENTS

Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

Policy Article

Revision Effective Date: 11/05/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements

Wheelchair Options/Accessories

LCD

Revision Effective Date: 01/01/2016

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: HCPCS code E1012 to Power Tilt and/or Recline Seating Systems range

HCPCS CODES:

Added: HCPCS code E1012

Revised: K0017 and K0018 long narrative description

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)

Policy Article

Revision Effective Date: 01/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Standard Documentation Language to remove start date verbiage from Prescription Requirements (Effective 11/5/2015)

CODING GUIDELINES:

Added: HCPCS code E1012

Added: HCPCS code E1012 to bundling table

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.*

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

This is a revision to previous version (with the same title), published May 29, 2015 and adds the new HCPCS code for Akynzeo®.

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

Akynzeo® is a fixed combination capsule comprised of two drugs, oral palonosetron (a 5HT3 antagonist) and netupitant (a NK-1 antagonist). The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Akynzeo® and determined that it is eligible for inclusion in the DME MAC Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) Local Coverage Determination (LCD), effective for claims with dates of service on or after October 10, 2014.

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

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

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

For dates of service on or after to July 1, 2015 through December 31, 2015, claims for Akynzeo® must be billed using HCPCS code:

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

For dates of service on or after January 1, 2016, claims for Akynzeo® must be billed using HCPCS code:

J8655 NETUPITANT 300 MG AND PALONOSETRON 0.5 MG

Akynzeo® (Q0181 or Q9978 or J8655) must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage. There must be no unbundling of the netupitant and palonosetron combination in Akynzeo®.

If Akynzeo® (Q0181 or Q9978 or J8655) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of the LCD regarding oral

antiemetics, a KX modifier must be added to each code. In addition to the diagnosis code corresponding to the beneficiary's cancer diagnosis, claims for these drugs must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy.

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

If Akynzeo® (Q0181 or Q9978 or J8655) and dexamethasone (J8540) are not used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of this policy, the GA or GZ modifier must be added to the claim lines for Q0181 and J8540. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

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

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

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

This is a revision to a previous version published February 20, 2015 and adds the new HCPCS code for blinatumomab.

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

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

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

Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

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

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

Claims for Blincyto™ for dates of service on or after December 03, 2014 through December 31, 2015, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME).

Claims for Blincyto™ for dates of service on or after January 1, 2016 must be submitted using HCPCS code J9039 (INJECTION, BLINATUMOMAB, 1 MICROGRAM).

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

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

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

This is a revision to a previous version published February 20, 2015 and adds the new HCPCS code for Duopa®

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

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

Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:

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

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

Claims for Duopa® for dates of service on or after January 09, 2015 through December 31, 2015 must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME).

Claims for Duopa® for dates of service on or after January 01, 2016 must be submitted using the HCPCS code J7340 (CARBIDOPA 5 MG/LEVODOPA 20 MG ENTERAL SUSPENSION).

Establishment of the transabdominal port with a PEG-J is performed under endoscopic guidance by a gastroenterologist or other healthcare provider experienced in this procedure. The PEG-J is considered a supply provided incident to a physician's service, and claims for this item are processed by the A/B MAC contractor. Claims to the DME MAC for the PEG-J will be rejected as wrong jurisdiction.

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

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

Correct Coding - IDEO™ and ExoSym™ Energy Storing AFO - Joint DME MAC Publication (O&P)

The US Army developed the Intrepid Dynamic Exoskeletal Orthosis (IDEO™) in 2009. A civilian version, ExoSym™, became available in 2013. The brace provides energy storage and return capabilities that an injured ankle is no longer able to provide. Recent claim experience has demonstrated that HCPCS coding guidance for Medicare billing is necessary to prevent errors.

Based upon a review of the published clinical literature and publically-available descriptive information, the correct combination of HCPCS codes for billing IDEO™, ExoSym™ and similar braces are:

L1945 - ANKLE FOOT ORTHOSIS, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION), CUSTOM FABRICATED

L2755 - ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, PER SEGMENT, FOR CUSTOM FABRICATED ORTHOSIS ONLY

Only HCPCS codes L1945 and L2755, in combination, may be used to bill for this type of brace. Use of the Not Otherwise Classified (NOC) HCPCS code L2999 is incorrect coding.

Refer to the Ankle Foot Orthosis / Knee Ankle Foot Orthosis (AFO/KAFO) Local Coverage Determination (LCD) and related Policy Article for additional information about coverage, coding and documentation.

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

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

This is a revision to a previous version published July 30, 2015 and adds the new HCPCS code for HYQVIA.

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 rejected as wrong jurisdiction.

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

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.

Claims for HYQVIA for dates of service from September 12, 2014 through December 31, 2015 must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME).

Claims for HYQVIA with dates of service on or after January 1, 2016 must be submitted using the HCPCS code J1575 (INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNEGLOBULIN).

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

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

Correct Coding - inFlow™ Intraurethral Valve-Pump (Vesiflo, Inc.) - DME MAC Joint Publication (SPE)

The inFlow™ Intraurethral Valve-Pump is a urinary device for women with incomplete bladder emptying due to impaired detrusor contractility (IDC). The inFlow™ is promoted as an alternative to urinary catheters. The device consists of a small catheter with an internal, magnetically-activated pump-valve mechanism. The inFlow™ is placed in the female urethra for up to 30 days. Upon activation by a battery-powered wand held low over the pubic area, the valve opens and the pump induces urine flow.

Effective 01/01/2016, the inFlow™ Intraurethral Valve-Pump was assigned HCPCS code A4335 (INCONTINENCE SUPPLY, MISCELLANEOUS). This HCPCS code must be used on claims for initial issue of inFlow™, and is all-inclusive (catheter, wand, and batteries). In addition, claims for replacement catheters, batteries, or wands must also use HCPCS code A4335.

Claims must include the manufacturer and product name in the narrative field of the electronic claim.

Refer to the Urological Supplies Local Coverage Determination and related Policy Article for additional information on coverage, coding and documentation.

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

Correct Coding - NOC Codes for Enteral (B9998) and Parenteral (B9999) Nutrition - DME MAC Joint Publication (PEN)

Recent claims analysis of the "Not Otherwise Classified" (NOC) codes used with enteral and parenteral nutrition claims identified errors in the use of these codes. This article will discuss the correct use of these NOC codes. The codes are:

- B9998 NOC FOR ENTERAL SUPPLIES
- B9999 NOC FOR PARENTERAL SUPPLIES

Correct coding requires the use of a specific HCPCS code for an item when a specific code exists. Use of a NOC code in place of a specific code represents incorrect coding.

Enteral Nutrition

The analysis of B9998 reviewed 909 claim lines finding that:

- 628 claim lines were identified as extension tubing.
- 61 claim line descriptions could not be deciphered to identify a specific item.
- 20 claim lines contained B9002 with MS, RR and/or KJ modifiers.
- 50 claim lines were identified as "per diem charges"

These claim lines are incorrectly coded.

The Enteral Nutrition Related Policy Article CODING GUIDELINES describe the requirements applicable to supplies used with enteral nutrition. The applicable supply allowance codes are:

B4034 ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

B4035 ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

B4036 ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

From the Coding Guidelines:

> **The codes for enteral feeding supplies (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the beneficiary for one day. Codes B4034-B4036 describe a daily supply fee rather than a specifically defined "kit".** Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors. These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. **These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape.** The use of individual items may differ from beneficiary to beneficiary and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding. (Emphasis added)

The supply allowance codes B4034-B4036 are all-inclusive, other than the feeding tube. Extension tubing and "per diem" charges for supplies must not be unbundled. "Per diem" charges for professional services associated with the provision of enteral nutrition likewise are not separately billable. Payment for professional services is included in the payment for all DMEPOS items.

Use of a NOC code to bill for an enteral pump is incorrect coding. B9000 (ENTERAL NUTRITION INFUSION PUMP - WITHOUT ALARM) and B9002 (ENTERAL NUTRITION INFUSION PUMP - WITH ALARM) are separately billable, specific HCPCS codes to be used for these items.

Suppliers are reminded to be sure that the submitted product information clearly identifies the item for which the NOC code is being used.

Parenteral Nutrition

The Analysis of B9999 reviewed 1196 claim lines finding that:

- 754 claim lines were identified as "per diem charges"
- 313 claim lines were identified as an IV securement device. An IV securement device is used to secure an IV to the beneficiary to ensure it is not dislodged.
- 26 claim lines were identified as the BioPatch®. The BioPatch® is a round antibacterial dressing with a slit to fit around the IV site in order to prevent infection.

These claim lines are incorrectly coded.

The applicable supply allowance codes for parenteral nutrition are:

B4220 PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY
B4222 PARENTERAL NUTRITION SUPPLY KIT; HOME MIX, PER DAY
B4224 PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY

The supply allowance codes B4220-B4224 are all-inclusive. Intravenous securement devices, the BioPatch® dressing, and "per diem" charges for supplies must not be unbundled. "Per diem" charges for professional services associated with the provision of parenteral nutrition likewise are not separately billable. Payment for professional services is included in the payment for all DMEPOS items.

Refer to the Enteral Nutrition and Parenteral Nutrition LCDs and their related Policy Articles for additional information.

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

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

On October 23, 2015 the Food and Drug Administration (FDA) gave accelerated approval to YONDELIS® (trabectedin), a chemotherapy treatment for specific soft tissue sarcomas (STS) - liposarcoma and leiomyosarcoma - that cannot be removed by surgery (unresectable) or is advanced (metastatic). This treatment is approved for patients who previously received chemotherapy that contained anthracycline.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated YONDELIS® and determined that it is not eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD L33794).

Claims to the DME MACs for YONDELIS® whose administration is initiated in a provider's office will be rejected as wrong jurisdiction. Please consult with the appropriate A/B MAC for potential reimbursement under part B of the Medicare program.

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

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

Reminder - Ordering Physician and CMS-1500 Claim Form - Joint DME MAC Publication (GEN)

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have noted an increase in Comprehensive Error Rate Testing (CERT) program denials when the name and national provider identifier (NPI) of the referring provider, listed in Block 17 and Block 17b of the CMS-1500 claim form do not match the name and NPI of the physician who completed the order. Title XVIII §1833(q) of the *Social Security Act* requires the referring/ordering physician information be submitted on a Medicare claim when the billing provider/supplier has received a referral or order for the referred/ordered service(s) or item.

This type of error can occur as the result of Medicare beneficiaries who are under the care of multiple physicians or the death, reassignment or retirement of their primary care provider, resulting in a change in providers. Suppliers are strongly encouraged to check their documentation from referring physicians or other healthcare practitioners and ensure that the information listed in Block 17 and Block 17b on the CMS-1500 form for the referring provider matches the information on the order for any item of durable medical equipment, orthotics, prosthetics or supplies (DMEPOS).

Completion of Certificates of Medical Necessity - Annual Reminder - Joint DME MAC Publication (GEN)

Dear Physician:

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

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

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

Printable copies of CMNs and DIFs are available on the CMS Website at:
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

To find a CMN/DIF, enter the name or form number in the "Filter On" field. For instance, if you are searching for the Oxygen CMN, enter "oxygen" or "484".

Remember, everyone has tight cash flow these days - help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Sincerely,

Wilfred Mamuya, MD, PhD
Medical Director
DME MAC, Jurisdiction A

Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder - Joint DME MAC Publication (GEN)

Requirements

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

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

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

Documentation Requirements

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

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

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

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

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

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

Billing Frequencies

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

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

Miscellaneous

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

For additional information, refer to CMS' *Program Integrity Manual*, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.8 and 5.2.9, and the applicable Local Coverage Determinations and the *Supplier Manual*.

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

Historical Review Results

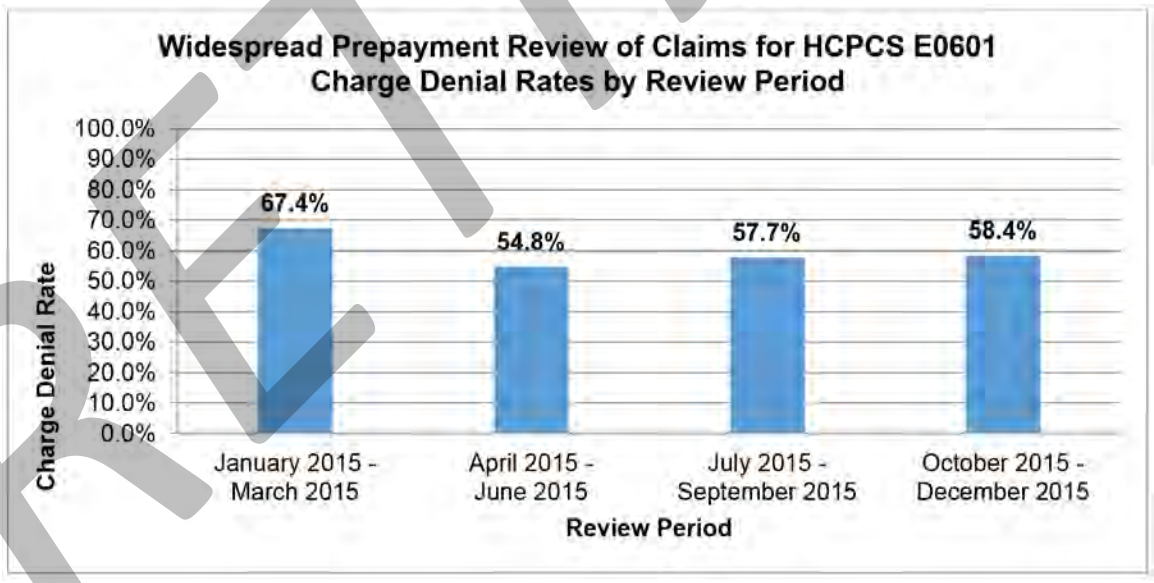
This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The overall Charge Denial Rate (CDR) is the total denied allowance amount (dollar amount of services determined to be billed in error) divided by the total allowance amount (dollar amount of services medically reviewed). The previous quarterly findings covered claims reviewed from July 2015 through September 2015, and reported a CDR of 57.7%

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from October 2015 through December 2015. This review involved prepayment complex medical review of 1613 claims submitted by 335 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 177 (11%) of the claims. Of the 1436 claims for which responses were received, 454 claims were allowed and 982 were denied/partially denied. This resulted in a claim denial rate of 68%. The overall CDR was 58.4%.

Charge Denial Rate Historical Data

The following graph depicts the Charge Denial rate from previous periods to current:



Primary Reasons for Denial

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

Face-to-Face Clinical Evaluation Documentation Issues

- 22% of the denied claims had insufficient Face-to-Face clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP LCD. The insufficient clinical documentation included:
    - Missing Face-to-Face
    - Untimely Face-to-Face
    - Face-to-Face does not meet criteria based documentation submitted. Clinical documentation provided did not reflect the need for the care provided or no detailed narrative in the clinical documentation describing symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores.
    - Face-to-Face is illegible due to poor fax quality or illegible handwriting
    - Medical documentation not authenticated by the author.

Scenarios included:

A. Beneficiaries seeking initial coverage of a PAP device
B. Beneficiaries seeking PAP replacement following the 5 year RUL
C. Beneficiaries seeking PAP replacement upon entering Fee-for-Service (FFS) Medicare

An E0601 device is covered when the beneficiary has a Face-to-Face clinical evaluation by treating clinician which meets PAP LCD criteria prior to the sleep test to assess the beneficiary for Obstructive Sleep Apnea. For beneficiaries entering FFS Medicare, a sleep test which meets criteria prior to the Face-to-Face is acceptable. For beneficiaries seeking PAP replacement following the 5 year RUL, a sleep test does not need to be submitted.

Detailed Written Order/Written Order Prior to Delivery Issues

- 19% of the denied claims had an incomplete Written Order Prior to Delivery (WOPD) for PAP device E0601.
  Included in these results for incomplete WOPD 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 (DWO) on or before delivery
    H. DWO not submitted, illegible or is written before the Face-to-Face

- 74% of the claims had an incomplete DWO PAP accessories.
  Included in these for incomplete DWO were orders which were missing either:
    A. Beneficiary's name
    B. Physician's name
    C. Date of the order
    D. Detailed description of item(s) ordered
    E. Items to be dispensed
    F. Physician signature and signature date

Also included in this calculation are orders which contain incompatible combinations

Sleep Study Documentation Issues

- 5% of the denied claims had insufficient Sleep Study documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP LCD. The insufficient clinical documentation included:
    A. No Sleep Study submitted
    B. Sleep test results which meet Medicare coverage criteria
    C. Sleep Study interpretation per the PAP LCD

Training Documentation Issues

- 5.1% of the denied claims did not include evidence of training on the PAP device.
- 9.6% of the denied claims did not include evidence of beneficiary training (by entity conducting the test) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a Face-to-Face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 2.2% of the denied claims were missing proof of delivery.
- 7.5% of the denied claims had proof of delivery which were missing either the beneficiary's name, delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or beneficiary's signature. (Refer to Article: *Proof of Delivery Reminder* found in the below *Educational References* section)

Claim Examples

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

Example 1:

Received: A DWO/WOPD, a Sleep Test that meets the Medicare coverage criteria, evidence of training on the PAP device, proof of delivery containing replacement items, and Face-to-Face clinical evaluation by the treating physician.
Insufficient: DWO lists incompatible combinations. Some suppliers use preprinted forms for their DWOs that include a listing of many different items, not all of which may be needed by an individual beneficiary. The final document that is signed and dated by the physician must clearly identify the specific items that are being ordered for the beneficiary. (Refer to article *Detailed Written Orders* found in the below *Educational References* section)

Example 2: (Initial coverage of PAP)

Received: Face-to-Face clinical evaluation, a DWO/WOPD, evidence of training on the PAP device and a diagnostic Sleep Test.
Incomplete/Insufficient: Proof of Delivery is missing a sufficient description of item(s) delivered. Unable to identify item(s) delivered.

Example 3:

Received: A DWO/WOPD, a Face-to-Face clinical evaluation by treating physician, Home Sleep Study, proof of delivery, and evidence of Training on the PAP device
Missing: Documentation submitted did not include information to support that the beneficiary received instruction for the application and use of a portable sleep monitoring device for a home sleep study either by Face-to-Face, video or telephonic instruction.

Next Step

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

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

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

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

NHIC offers a self-service tool, Decision Desktop, which allows suppliers direct access to specific details about a claim decision for claims which have been selected for Complex Medical Review. This tool enables the direct access to comprehensive information

relating to the reason for denial along with saving time since it is no longer necessary to contact Customer Service for this information.

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

Educational References

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

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review of Claims for HCPCS E0601 (Continuous Positive Airway Pressure Devices) (posted 11/25/15, 8/27/15, 5/29/15, and 2/26/15)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- DME MAC Jurisdiction A Supplier Manual - Chapter 10 - Durable (Chapter 10 - Durable Medical Equipment) for additional information regarding general coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Items Provided on a Recurring Basis and Refill Requirements - Joint DMC MAC Publication
  http://www.medicarenhic.com/viewdoc.aspx?id=2933
- Proof of Delivery Reminder
  http://www.medicarenhic.com/viewdoc.aspx?id=2928
- Detailed Written Orders
  http://www.medicarenhic.com/viewdoc.aspx?id=422
- Live Line Chat - Online chat sessions to ask billing, policy, documentation and other general questions
  http://www.medicarenhic.com/dme/rcseminars.aspx#liveline

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

Historical Review Results

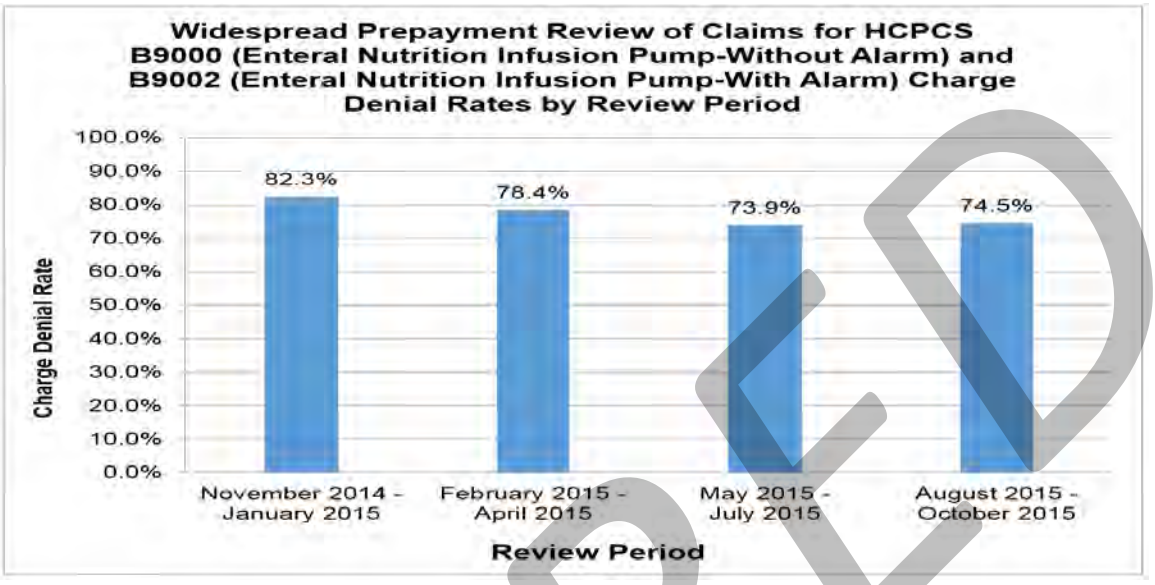
DME MAC JA Medical Review continues to review Enteral Nutrition Infusion Pump-Without Alarm (B9000) and Enteral Nutrition Infusion Pump-With Alarm (B9200), based on the results of the previous prepayment widespread review. The result of the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed is the Charge Denial Rate (CDR). The previous review included claims reviewed May 01, 2015 - July 31, 2015, which resulted in 73.9% 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 August 01 thru October 31, 2015. The review involved prepayment complex medical review of 791 claims submitted by 108 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 126 (16%) of the claims. For the remaining claims, 133 claims were allowed, and 532 were denied/partially denied resulting in a claim denial rate of 80 % and a Charge Denial Rate of 74.5%.

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 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 (42%)

- 6% of the claims denied statutorily - did not meet prosthetic benefit requirement
- 15% of the denied claims did not have any medical record documentation submitted
- 21% of the denied claims had insufficient clinical documentation demonstrating that the beneficiary meets the prosthetic benefit

Note: *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*

Proof of Delivery Issues (31%)

- 17% of the denied claims had no Proof of Delivery (POD)
- 14% of the claims had incomplete delivery information
  - Included a POD that was not sufficiently detailed to identify the item(s) being delivered
  - Missing the beneficiary name on POD

Detailed Written Order (DWO) Issues (30%)

- 14% of the denied claims did not include a DWO
- 12% of the denied claims had incomplete DWOs
  - Date of the DWO was incomplete (missing order date)
  - DWO submitted did not meet record keeping principles
  - DWO included a stamped signature
  - DWO included a clinician signature date that was illegible
  - Dispensing order only
- 4% of the denied claims included DWOs in which the Physician signature could not be authenticated

DME Information Form (DIF) (7%)

- 4% of the denied claims did not include a DIF
- 3% of the denied claims included a DIF that did not list the Enteral Pump HCPCS code

Claim Examples

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

Example 1:

Received: DWO, DIF, Clinical Documentation
Missing: POD; DWO did not include: Description of the item, Beneficiary's name, Prescribing physician's name

Example 2:

Received: Medical documentation that supports the prosthetic benefit and enteral infusion pump, DIF
Missing: all elements of DWO, as well as POD

Example 3:

Received: All elements of DWO and POD
Missing: DIF, Clinical documentation that supports diabetic enteral formula and enteral infusion pump

Next Step

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

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

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

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

Educational References

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

- Enteral Nutrition (L33783) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L33783) (posted 06/26/14, 09/25/14, 12/18/14, 03/26/15, 06/26/15, 9/29/15)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- DME MAC Jurisdiction A Supplier Manual (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- CERT Physician Letter - Enteral Nutrition
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/selfservice.aspx

Results of Widespread Prepayment 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 42.1%. A summary of findings was published on the NHIC, Corp. Website on October 29, 2015. Based on this result, a widespread prepayment review was continued.

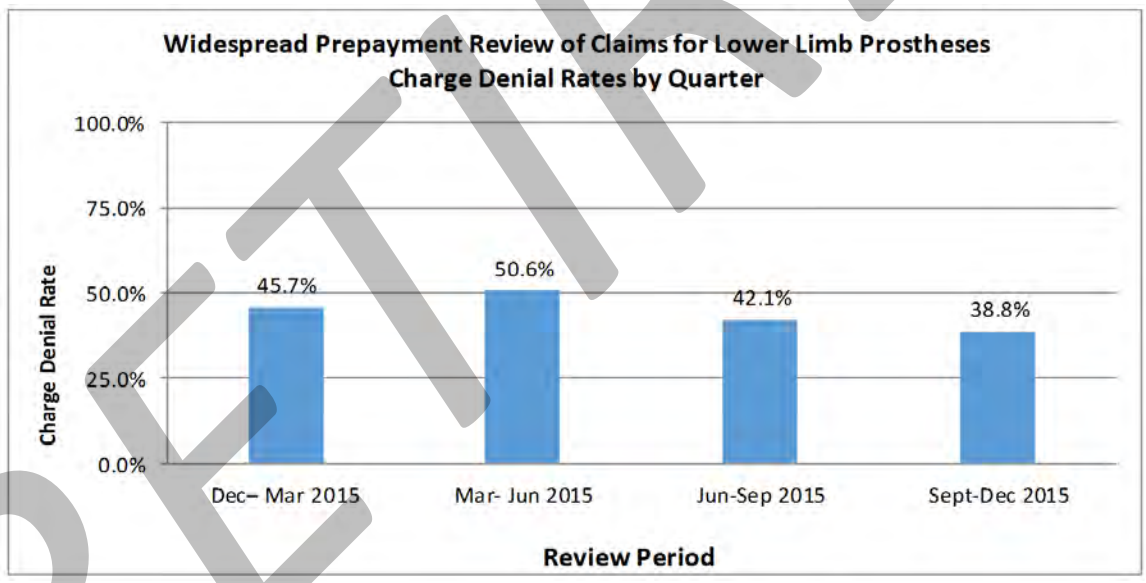
Current Review Results

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

The review involved prepayment complex medical review of 229 claims submitted by 151 suppliers for claims processed September 02, 2015 to December 05, 2015. Responses to the Additional Documentation Request (ADR) were not received for 24 (10%) of the claims. For the remaining 205 claims, 110 claims were allowed and 95 were denied resulting in a claim denial rate of 46%. The overall Charge Denial Rate was 38.8%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Lack of Medical Record Documentation

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

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

- 11% 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

- 4% 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

- 20% 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 date of the order; Proof of Delivery that includes the manufacturer, model numbers, 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 date of the order; An invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the prosthetist's 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 verifying that the beneficiary received the items that were billed.

Example 3:

Received: The supplier submitted a Detailed Written Order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and date of the order; Proof of Delivery that includes the manufacturer, model numbers, verifying that the beneficiary received the items that were billed; The prosthetist's evaluation/assessment detailing the functional level of the items billed; Clinical documentation to support functional level of the device and to corroborate the prosthetist's records.
Missing: Information by the ordering physician, either on the Detailed Written Order or in the medical record, demonstrating the reason for replacement.

Next Step

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

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

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

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

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

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

Educational References

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

- LCD for Lower Limb Prostheses (L33787) and related Policy Article (A52496)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- DME MAC Jurisdiction A Supplier Manual (Chapter 10 - Durable Medical Equipment) Includes Standard Documentation Requirements
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/mobile/index.html
- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Lower Limb Prostheses Documentation Reminder for Physicians
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (posted 01/29/15, 04/23/15, 07/30/15, 10/29/15)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Live Line - Online chat sessions to ask billing, policy, documentation, and other general questions
  http://www.medicarenhic.com/dme/rcseminars.aspx#liveline

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 June 2015 through August 2015 and resulted in a CDR of 95.5%.

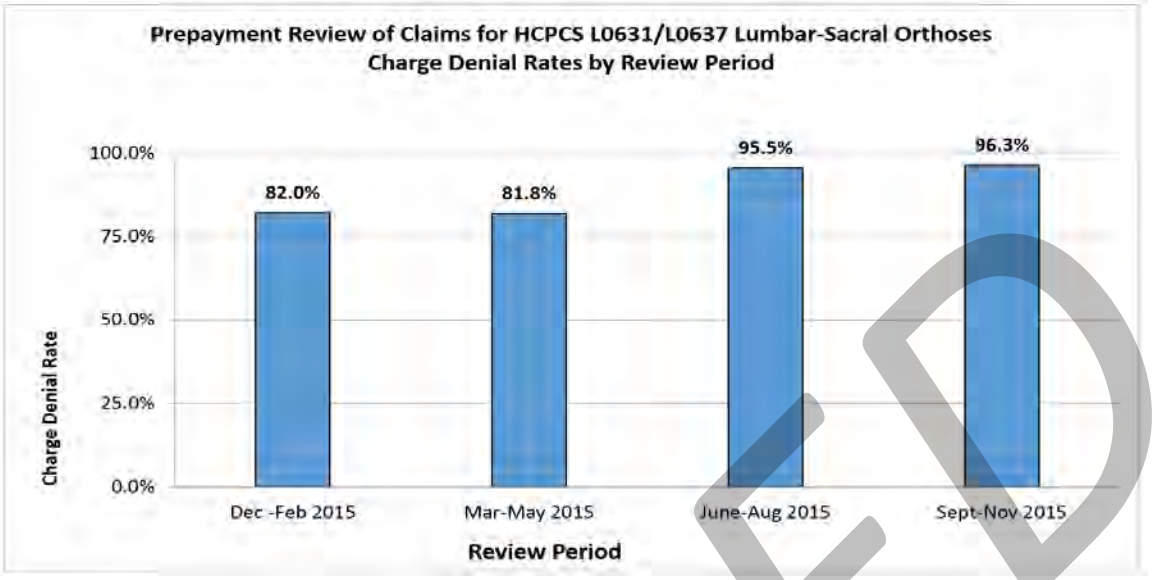
Current Review Results

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

The review involved prepayment complex medical review of 1,511 claims submitted by 398 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 384 (25%) of the claims. For the remaining 1,127 claims, 26 claims were allowed and 1,101 claims were denied resulting in a claim denial rate of 98%. The overall CDR was 96.3%.

Charge Denial Rate Historical Data

The following graph depicts the Charge Denial Rate from previous review periods to current:



Primary Reasons for Denial

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

Detailed Written Orders Issues

- Denied claims were missing a Detailed Written Order (DWO) (20.4%)
- Denied claims included an incomplete DWO (11.9%)
    - DWOs submitted were not legible and/or did not list beneficiary name (1.5%)
    - DWOs missing date of the order and/or signature date (1.4%)
    - DWOs were missing a detailed description of the requested Lumbar Sacral Orthotic (s) the detailed description in the written order may be either a narrative description or a brand name/model number (9%)

Clinical Documentation Issues

- Denied claims missing clinical documentation to support medical necessity (10.8%)
- Denied claims upon review of clinical documentation (88%)
    - Medical documentation was not authenticated by the clinician conducting the exam (1.8%)
    - Clinician/supplier notes submitted did not support medical necessity. The documentation submitted did not meet the coverage criteria for a custom fitted orthosis. As stated in the LCD, a prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (86.2%)

Proof of Delivery Issues

- Denied claims were missing the Proof of Delivery (POD) (10.6%)
- Proof of Delivery (POD) included delivery documentation was missing required element (4.1%)
    - Delivery documentation (Method 1) did not include signature of beneficiary or beneficiary's representative; unable to determine if beneficiary received items billed (1%)
    - Dates of service do not match shipping/receipt dates for items, as defined within LCD (L33790) (1%)
    - Delivery documentation does not include delivery address (1.1%)
    - Delivery documentation does not specify the requested Lumbar-Sacral-Orthosis, and it is unclear from the description which orthotic is being delivered. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary. (1%)

Claim Examples

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

Example 1:

Received: The supplier submitted a completed DWO, clinical documentation, and a POD.
Missing: The documentation does not meet the coverage criteria for a custom fitted orthosis. There must be documentation from the supplier/fitter, which demonstrates extensive modifications were made to the orthotic prior to delivery. "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."

Example 2:

Received: The supplier submitted a completed DWO, POD, clinical documentation and supplier notes.
Missing: The clinical documentation submitted is after the date of service. It is unclear if the item requested was necessary at the time the orthotic was ordered. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial date of service (DOS) to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

Example 3:

Received: The supplier submitted clinical documentation, fitter notes, and a POD.
Missing: The dispensing order does not contain a verbal order from the physician and is not signed. There must be a completed DWO submitted with each claim. The fitter notes state "The brace was fitted to the beneficiary". This does not give enough information to determine that the orthotic was modified by a person with expertise, prior to delivery.

Next Step

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

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

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

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

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

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

Educational References

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

- LCD for Spinal Orthoses: TLSO and LSO (L33790)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx

- DME MAC Jurisdiction A Supplier Manual (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- Results of Prepay Probe for Lumbar-Sacral Orthoses
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Supplier Self Audits
  http://www.medicarenhic.com/dme/selfaudits.aspx

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 May 2015 through July 2015, and reported a CDR of 69.2%.

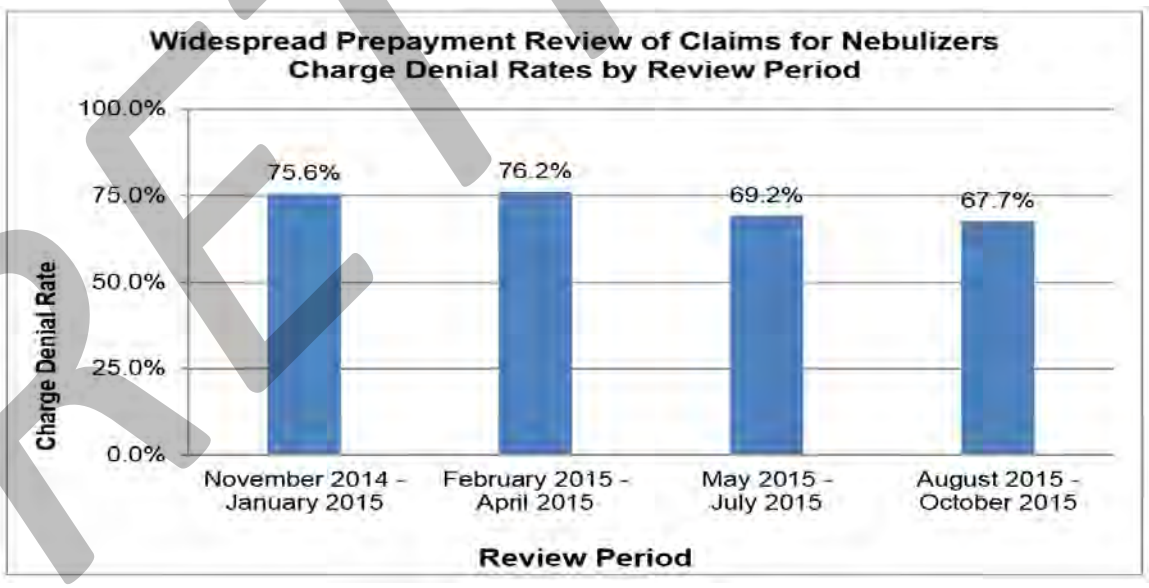
Current Review Results

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

The review involved prepayment complex medical review of 1,585 claims submitted by 541 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 356 (22%) of the claims. For the remaining 1,229 claims, 280 claims were allowed (23%) and 949 were denied/partially denied resulting in a claim denial rate of 77%. The overall CDR was 67.7%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Clinical Documentation Issues

- 14% of claims were denied because no medical records were submitted
- 31% of the denied claims had insufficient or incomplete clinical documentation. The following are common issues identified with clinical documentation:
    - Clinical documentation did not support reasonable and necessary use of a nebulizer
        - Clinical documentation submitted did not mention a covered 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 WOPD.
- 34% of the denied claims had an incomplete or invalid WOPD. The following are common issues identified:
    - Missing the prescribing practitioner's National Provider Identifier (NPI)
    - Ordering practitioner signature date was after the item(s) were delivered
    - Insufficient evidence (i.e. date stamp, fax date, etc.) within the documentation to show that the supplier received the written order prior to delivering the item(s)

Proof of Delivery Issues

- 4% of the denied claims were missing proof of delivery.
- 10% of the denied claims had an incomplete or invalid proof of delivery. The following are common issues identified:
    - Illegible copy of proof of delivery
    - Missing sufficiently detailed description to identify the item(s) being delivered
    - Missing beneficiary (or designee) signature when item(s) are delivered directly by the supplier to the beneficiary
    - Nebulizer (first month rental) delivered to the beneficiary either before or after the date of service of the claim when delivered directly by the supplier (Method I)
    - Nebulizer (first month rental) shipped either before or after the date of service of the claim when the item(s) is shipped via a shipping service or delivery service (Method II) directly to a beneficiary

Claim Examples

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

Example 1:

Received: WOPD with: beneficiary name, description of item to be dispensed, physician's signature, date of signature, physician's NPI number, clinical notes and proof of delivery

Reason for Denial: Invalid alteration to the physician's NPI number on the WOPD. Insufficient evidence (i.e. Date stamp or similar) within the documentation submitted to show that the supplier received the WOPD prior to delivering the item(s). Proof of delivery missing a sufficiently detailed description (e.g., brand names, serial number, narrative description) of an E0570 nebulizer, with compressor.

Example 2:

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

Reason for Denial: The physician's signature date on the WOPD is after the item(s) were delivered. Insufficient evidence (i.e. Date stamp or similar) within the documentation submitted to show that the supplier received the WOPD prior to delivering the item(s). The proof of delivery submitted shows that the item(s) were delivered before the date of service on the submitted claim.

Example 3:

Received: WOPD with: beneficiary name, description of item to be dispensed, physician's signature, date of signature, physician's NPI number, evidence of supplier receipt of the detailed written order prior to delivery and clinical notes.
Reason for Denial: Clinical notes submitted did not demonstrate the reasonable and necessary use of a small volume nebulizer, with compressor, for the administration of albuterol for the management of a diagnosis supported by the Local Coverage Determination (LCD). Missing proof of delivery.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for E0570 (Nebulizer, with Compressor).

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

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

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

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

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

Educational References

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

- Nebulizers (L33370) LCD and Policy Article (A52466)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- Results of Widespread Prepayment Review of Claims for E0570 (posted 12/18/14, 03/26/15, 06/25/15, 09/24/15)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- DME MAC Jurisdiction A Supplier Manual (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Frequently Asked Questions (search word "nebulizer")
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- Face-to-Face and Written Order Requirements for High Cost DME - Dear Physician Letter
  http://www.medicarenhic.com/dme/mobile/index.html
- Live Line - Online chat sessions to ask billing, policy, documentation, and other general questions
  http://www.medicarenhic.com/dme/rcseminars.aspx
- Nebulizer Checklist
  http://www.medicarenhic.com/dme/mobile/index.html

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

Historical Review Results

This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed result is the Charge Denial Rate (CDR). The previous quarterly findings covered the period of July 01, 2015 through September 30, 2015 and resulted in a CDR of 58.8%.

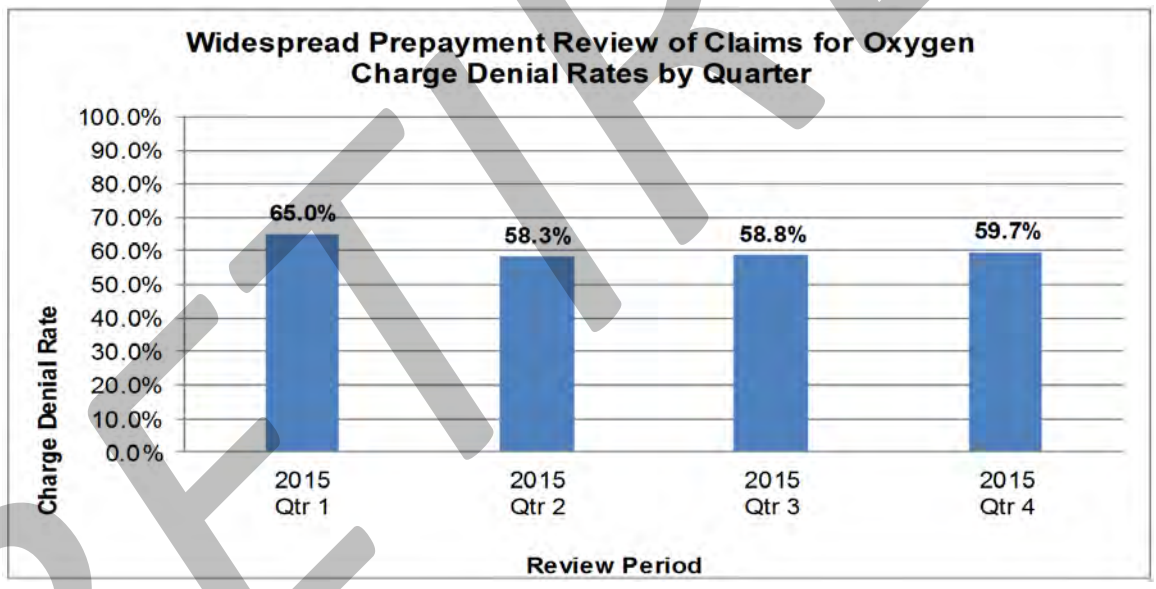
Current Review Results

DME MAC JA 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 October 01, 2015 through December 31, 2015.

The review involved prepayment complex medical review of 519 claims submitted by 120 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 221 (43%) of the claims. For the remaining 298 claims, 114 claims were allowed and 184 were denied/partially denied resulting in a claim denial rate of 62%, and a CDR of 59.7%.

Charge Denial Rate Historical Data

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



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

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

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated in the LCD, and
3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
    a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or

b. If the qualifying blood gas study is not performed during an inpatient stay, the reported test must be performed while the beneficiary is in a chronic stable state - i.e. not during a period of acute illness or an exacerbation of their underlying disease, and

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Refer to the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L33797 and related Policy article for additional information.

Primary Reasons for Denial

The following are the primary reasons for denial.

Written Order Prior to Delivery Requirements Not Met (36%)

Documentation did not meet the written order prior to delivery requirements for items E0431 and E0439 outlined in LCD L33797 for dates of service on or after January 01, 2014 for the following reasons:

- Detailed written order was signed after the date of delivery
- Detailed written order was received after the date of delivery
- No evidence, by date stamp or similar, that the supplier received the detailed written order prior to delivery
- Detailed written order was missing a detailed description of the DME item(s) ordered
- No detailed written order was submitted
- Detailed written order was missing the prescribing practitioner's NPI
- Correction was made to the detailed written order without the author's initials and the date of the correction
- Detailed written order was missing the prescribing practitioner's signature date
- Detailed written order was received by the supplier prior to the signature date
- Detailed written order was illegible
- Detailed written order was missing the prescribing practitioner's printed name

Missing Documentation (31%)

Missing required physician visit per Local Coverage Determination (LCD) L33797:

- 14% - Missing treating physician visit dated within 30 days prior to the initial certification date

Missing qualifying blood gas study per LCD L33797:

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

Missing required Certificate of Medical Necessity (CMN) per LCD L33797:

- 7% - Missing a valid initial CMN
  - Initial CMN not submitted
  - Initial CMN missing required information or required information was illegible
  - Initial CMN contained corrections that did not include a single strikethrough, the author's initials and the date of the correction

Missing required Detailed Written Order per LCD L33797

- 1% - Missing a detailed written order for item E1390

Missing valid proof of delivery per LCD L33797

- 4% - 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 a description of the items delivered

Clinical Documentation Issues (24%)

Clinical documentation did not support criteria of LCD L33797 for the following reasons:

- 11% - 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
- 10% - Documentation of a blood gas study performed during exercise did not meet testing criteria

  - Missing beneficiary's saturation exercising with oxygen applied
  - Missing beneficiary's saturation on room air at rest
- 4% - Documentation of a blood gas study performed during sleep did not meet testing criteria
  - Oxygen saturation reported on the CMN was not the lowest value that occurred during the testing period
  - No documentation of a titration polysomnogram for a beneficiary with obstructive sleep apnea
- 4% - Group I criteria was not met
  - Exercise testing documentation did not support that the beneficiary's oxygen saturation was at or above 89 percent during the day while at rest
  - Documentation did not support that the beneficiary's oxygen saturation was at or below 88%
- 3% - No indication in the medical documentation of the presence of a severe lung disease or hypoxia-related symptoms
- 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 4/18/15
Codes Billed: E1390, E0431

Documentation Received: Proof of delivery signed by the beneficiary on 4/18/12 (*not a typo, this was the date on the proof of delivery received*); initial CMN dated 4/17/15; detailed written order signed 5/15/15 and documented as received on 5/15/15; supplier forms; physician progress note dated 4/17/15 documenting the qualifying diagnosis and supporting the results of the blood gas study reported on the initial CMN
Missing: Detailed written order signed and received prior to delivery of the items ordered; physician's signature on the progress note dated 4/17/15, proof of delivery signed and dated 4/17/15

Example 2
DOS 7/29/15
Codes Billed: E1390

Documentation Received: Initial CMN dated 7/29/15; physician progress note dated 7/29/15 documenting the qualifying diagnosis and supporting the results of the blood gas study reported on the initial CMN; proof of delivery signed by the beneficiary on 7/29/15
Missing: Documentation of the beneficiary's oxygen saturation exercising with oxygen applied to meet the testing requirement for a blood gas study performed during exercise

Example 3
DOS 5/15/15
Codes Billed: E1390, E0431

Documentation Received: Dispensing order dated 5/13/15; physician progress notes dated 4/16/15 and 4/21/15 documenting the need for oxygen therapy; titration polysomnogram dated 5/6/15; proof of delivery signed by the beneficiary on 5/15/15; detailed written order signed 5/26/15
Missing: Detailed written order signed and documented as received by the supplier prior to the date of delivery; initial CMN

Next Steps

Based on the results of this prepayment review, DME MAC JA 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 JA 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 JA Provider Compliance mailbox at:
dme_mac_jurisdiction_a_provider_compliance@hpe.com

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

Educational References

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

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L33797 and related Policy Article (A52514)
  http://www.medicarenhic.com/dme/mrlcdcurrent.aspx
- DME MAC Jurisdiction A Supplier Manual (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/supmandownload.aspx
- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerccertrec.aspx
- Physician Letter - Home Oxygen Initial Qualification Testing
  http://www.medicarenhic.com/dme/mobile/index.html
- Physician Letter - Face-to-Face and Written Order Requirements for High Cost DME
  http://www.medicarenhic.com/dme/mobile/index.html
- Oxygen Highlights & Headlines
  http://www.medicarenhic.com/dme/dmeoxychanges.aspx
- Frequently Asked Questions (search word oxygen)
  http://www.medicarenhic.com/faqs.aspx?categories=DME
- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (posted 11/25/15, 8/27/15, 5/29/15, 2/26/2015)
  http://www.medicarenhic.com/dme/mrbulletinpca.aspx
- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/viewdoc.aspx?id=2969
- Proof of Delivery Reminder Joint DME MAC Publication
  http://www.medicarenhic.com/viewdoc.aspx?id=2928
- Live Line - Online chat sessions to ask billing, policy, documentation, and other general questions
  http://www.medicarenhic.com/dme/rcseminars.aspx#liveline

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

1099-MISC Form Information (GEN)

NHIC, Corp. mailed all 1099 Forms for calendar year (CY) 2015 on January 21, 2016. Suppliers can expect 1099 Forms to arrive within 7-10 business days from the date of mailing.

NHIC, Corp. will issue a 1099 reflecting payments made on the Jurisdiction A Durable Medical Equipment Medicare Administrative Contract (DME MAC) by NSC/PTAN from NHIC for CY 2015.

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

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

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

Common Question/Concerns

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

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

What address will my 1099 be mailed to?

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

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

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

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

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

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

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

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

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

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

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

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

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

Physicians, Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists - Are You Ordering Positive Airway Pressure (PAP) Devices For Your Patient? (OXY)

Medicare can make payment for PAP equipment and supplies when the patient's medical record shows the patient has Obstructive Sleep Apnea and meets medical documentation, test results, and health conditions as specified in the CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.4 (https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=226)

Medical record documentation determines whether your patient can receive the PAP equipment and supplies you have prescribed and the amount of the patient's out of pocket expenses.

Medical record documentation must show an in-person or face-to-face interaction with your patient within six (6) months prior to prescribing the item, specifically to document the patient was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. For the initial evaluation, the report would commonly document pertinent information such as - signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches; the duration of those symptoms and a validated sleep hygiene inventory, but may include other details as well. Also a pertinent physical examination assessing - e.g., body mass index, neck circumference, upper airway exam and cardiopulmonary exam. It is not necessary for all of the above to be present, however it is critical that there be detailed information that identifies symptoms commonly associated with Obstructive Sleep Apnea. Multiple treating practitioners may be involved in patient care. The practitioner conducting the face-to-face visit may be different than the ordering practitioner, however the ordering practitioner must have access to evaluate the medical record.

Your patient must have a facility-based polysomnogram or a Type II, III, or IV home sleep study after your in-person evaluation, demonstrating an Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to 15 events per hour with a minimum of 30 events per hour or an AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease or history of stroke. This sleep study must take place on the same date or after the in-person or face-to-face interaction documenting signs and symptoms of OSA.

The prescription must include a detailed description of the item(s) being ordered. The order must also include the order date, patient name, your name, National Provider Identifier (NPI), signature and signature date. You must supply this signed order and the medical record documentation of your face-to-face evaluation to the supplier before they can deliver the PAP device to your patient. Please note that while PAP accessories may be provided from a dispensing order, this must be followed up with an order containing a detailed description for each item provided to your patient.

Your medical record documentation must also show a face-to-face re-evaluation with your patient between the 31st and 91st day after initiating therapy with a notation that the patient's symptoms of Obstructive Sleep Apnea are improving. Your medical record documentation must also demonstrate the patient is adhering to the therapy and that you have reviewed this adherence. Adherence to therapy is defined as use of the PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

Following this guidance will help your patients and the Medicare program by verifying that there is medical documentation to support the provision of a Positive Airway Pressure Device and allow your patient to receive the therapy needed to treat their condition. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the device and accessories you have prescribed.

Fourth Quarter 2015 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for October through December 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	80,919	The procedure code, modifier, or procedure code and modifier combination is invalid.
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.	18,381	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.HI01-2.050 If 2400.SV107-1, SV107-2, SV107-3, or SV107-4 is "1" and 2300.HI01-1 is "ABK" then 2300.HI01-2 must be a valid ICD-10-CM Diagnosis code	18,133	Must be a valid ICD-10-CM Diagnosis code on the date in 2400.DTP03 when DTP01 = "472", based on the ICD-10-CM Diagnosis Code list table.
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	15,947	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.087.2010AA.NM109.050 Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	11,759	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 Website and return to CEDI for processing.
X222.094.2010AA.REF02.050 Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	9,012	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.351.2400.SV101-3.040 The procedure code modifiers in SV101 must not be duplicated within the same detail service line.	8,994	The procedure code modifiers in SV101 must not be duplicated within the same detail service line.
X222.351.2400.SV101-3.020 Procedure Modifier must be valid for the Service Date. (DTP01 = "472")	8,113	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	7,059	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES website matches the information at the NSC.
X222.226.2300.HI01-2.130 Duplicate diagnosis codes cannot be sent on the same HI segment in a claim.	6,656	If 2300.HI01-1 equals BK or ABK the Diagnosis codes within this HI segment must not be duplicated.

Fourth Quarter 2015 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the fourth 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 October through December 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.	27,396
OA109, N418 This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	13,272
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.	10,030
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.	2,364
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.	2,038
CO 16, M76 Missing / incomplete / invalid diagnosis or condition	**Item 21** - Claim/service lacks information with diagnosis code which is need for adjudication.	1,893
CO 16, M79 Missing / incomplete / invalid charge	**Item 24F** - Did not complete or enter the appropriate charge for each listed service.	1,852
CO 16, MA83 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	1,816
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.	753
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician..	736

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 JA 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 JA) *Supplier Manual* is available via the "*Publications*" section of our website at http://www.medicarenhic.com/dme/publications.aspx. After accepting the CPT License Agreement, suppliers can access the entire *DME MAC JA Supplier Manual*, including revised chapters and archived revisions.

Updates/Corrections Made:

In December of 2015 chapters 4, 6, 10, 12, and Appendix A of the *DME MAC JA Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

DME MAC A ListServes (GEN)

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

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

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

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Quarterly Provider Update (GEN)

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

Updating Supplier Records (GEN)

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

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

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

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

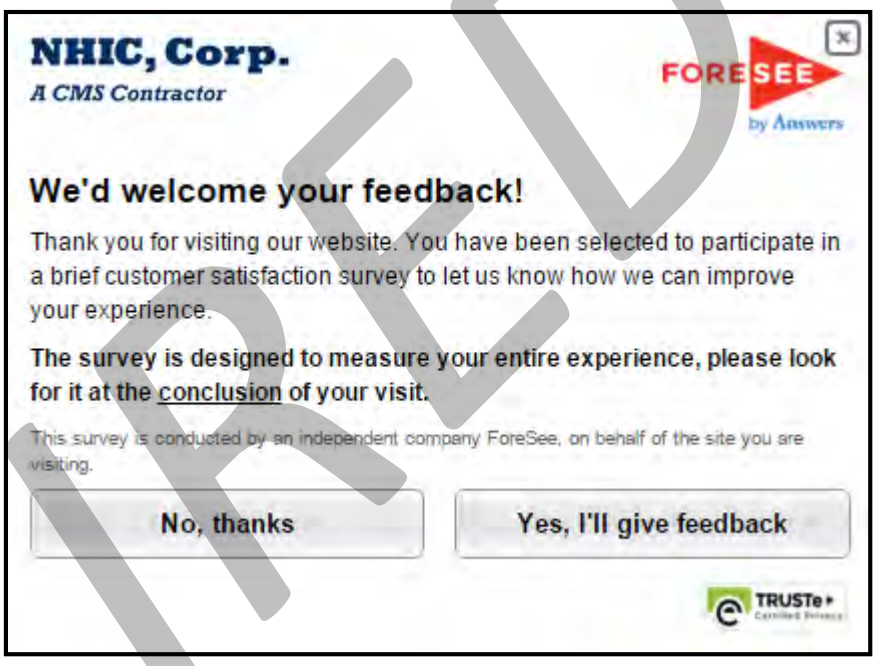
Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC Jurisdiction A Website Customer Satisfaction Survey (GEN)

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

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

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



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

CMS News Flash - Revised products from the Medicare Learning Network® (MLN):

- *ICD-10-CM/PCS Billing and Payment Frequently Asked Questions*, Fact Sheet (ICN 908974) **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD-10BillingandPaymentFAQs.pdf**
- The "*Quick Reference Information: Home Health Services*" Educational Tool (ICN 908504) in downloadable format. **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Quick_Reference_Home_Health_Services_Educational_Tool_ICN908504.pdf**


Medicare
Learning
Network®
Official Information Health Care
Professionals Can Trust
http://go.cms.gov/MLNGenInfo

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

outreach-education@hpe.com

Claims Submissions

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

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

Written Inquiries

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

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 844-687-2656

Redetermination Requests Fax:

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

Reconsiderations:
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

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

781-741-3118 **or** 781-741-3840

Redetermination For Overnight Mailings:
NHIC, Corp. DME MAC Jurisdiction A
Appeals
75 William Terry Drive
Hingham, MA 02044

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

Administrative Law Judge (ALJ) Hearings:
HHS OMHA Mid-West Field Office
BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Wilfred Mamuya, MD PhD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hpe.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hpe.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

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

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

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

DME MAC Jurisdiction A Resource

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

March 2016
Number 39

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
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NHIC, Corp.
A CMS Contractor

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