# DME Happenings

Jurisdiction A

**September 2016**

## In This Issue...

### FYI



### APPEALS



### CEDI



This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://www.med.noridianmedicare.com

Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select "Subscribe" on the bottom right-hand corner of any page.






Noridian Healthcare Solutions, LLC

## CERT



## CODING



## COMPETITIVE BIDDING



## DOCUMENTATION



## EDUCATIONAL



## ENROLLMENT



## ENTERAL AND PARENTERAL NUTRITION



## FORMS



## GLUCOSE MONITORS



## HOSPITAL BEDS

## IMMUNOSUPPRESSIVE DRUGS



## LCD AND POLICY ARTICLES



## NEBULIZERS



## ORTHOTICS AND PROSTHETICS



## OVERPAYMENTS AND REFUNDS



## OXYGEN



## PAP DEVICES



## PATIENT LIFTS



## POWER MOBILITY DEVICES

## PRESSURE REDUCING SUPPORT SURFACES



## REIMBURSEMENT



## REMITTANCE ADVICE



## THERAPEUTIC SHOES



## UPDATES



## UROLOGICAL SUPPLIES

# Alphabetical Listing

# Jurisdiction A DME MAC Supplier Contacts and Resources

| Phone Numbers | | |
|---|---|---|
| Interactive Voice Response System | 1-866-419-9458 | 24 hours a day, 7 days a week for Eligibility and general information<br>6 am – 5 pm ET<br>Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status |
| Supplier Contact Center | 1-866-419-9458 | 8 am – 5 pm ET Monday-Friday |
| Telephone Reopenings | 1-866-419-9458 | 8 am – 5 pm ET |
| Beneficiary Customer Service | 1-800-633-4227 | 24 hours a day/7 days a week |
| **Website: www.noridianmedicare.com/web/jadme** | | |
| **Fax** | | |
| Reopenings and Redeterminations<br>MSP Inquiries and Refunds<br>DME Recovery Auditor Redeterminations | | 1-701-277-2425 |
| Refunds to Medicare Immediate Offsets | | 1-701-277-2427 |
| DME Recovery Auditor Offsets | | 1-701-277-7896 |
| Medical Review Medical Documentation | | 1-701-277-2426 |
| CERT Medical Documentation | | 1-240-568-6222 |
| **Noridian Email Addresses** | | |
| Noridian DME Customer Service | | https://med.noridianmedicare.com/web/jadme/contact/email-customer-service |
| Reopenings and Redeterminations | | dmeredeterminations@noridian.com |
| Noridian Medicare Portal Support | | japortal@noridian.com |
| **Mailing Addresses** | | |
| **Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation**<br>Noridian JA DME<br>Attn: _____<br>PO Box 6780<br>Fargo, ND 58108-6780 | | **Benefit Protection**<br>Noridian JA DME<br>Attn: Benefit Protection<br>PO Box 6736<br>Fargo, ND 58108-6736 |
| **Administrative Simplification Compliance Act Exception Requests**<br>Noridian JA DME<br>Attn: ASCA<br>PO Box 6736<br>Fargo, ND 58108-6736 | | **Qualified Independent Contractor**<br>C2C Solutions, Inc.<br>Attn: DME QIC<br>PO Box 44013<br>Jacksonville, FL 32231-4013 |
| **Electronic Funds Transfer Forms/ Overpayment Redeterminations/ DME Recovery Auditor Redeterminations**<br>Noridian JA DME<br>Attn: _____<br>PO Box 6728<br>Fargo, ND 58108-6728 | | **DME Recovery Auditor Overpayments**<br>Noridian JA DME<br>Attn: Recovery Auditor Overpayments<br>PO Box 6780<br>Fargo, ND 58108-6780 |

| Other DME MACs | | |
|---|---|---|
| Jurisdiction D: NHS | 1-877-320-0390 | https://med.noridianmedicare.com/ |
| Jurisdiction B: CGS | 1-877-299-7900 | www.cgsmedicare.com |
| Jurisdiction C: CGS | 1-866-238-9650 | www.cgsmedicare.com |
| **Other Resources** | | |
| Pricing, Data Analysis and Coding | 1-877-735-1326 | www.dmepdac.com |
| National Supplier Clearinghouse | 1-866-238-9652 | www.palmettogba.com/nsc |
| Common Electronic Data Interchange Help Desk | 1-866-311-9184 | www.ngscedi.com |
| Centers for Medicare & Medicaid Services | | www.cms.gov |

## Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

| Organization | Phone Number | Types of Inquiries |
|---|---|---|
| **1-800-MEDICARE** | 1-800-633-4227 | General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary |
| **Social Security Administration** | 1-800-772-1213 | Changing address, replacement Medicare card and Social Security Benefits |
| **RRB – Railroad Retirement Board** | 1-800-808-0772 | For Railroad Retirement beneficiaries only – RRB benefits, lost RRB card, address change, enrolling in Medicare |
| **Coordination of Benefits** | 1-800-999-1118 | Reporting changes in primary insurance information |

Another great resource for beneficiaries is the website, http://www.medicare.gov/, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for and access MyMedicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information

- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

## CMS Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

## Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

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

## Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

**Source:** Internet Only Manual (IOM), Publication 100-4, *Medicare Claims Processing Manual*, Chapter 20, Section 200

## Fax Numbers for Claims and Correspondence

Fax numbers have been established for the Noridian Jurisdiction A DME suppliers. When faxing correspondence, please ensure the appropriate number for the correspondence being submitted is used as this will assist in timely processing of fax receipts.

View the Fax Numbers webpage for a complete listing.

## Holiday and Supplier Contact Center Closure Schedules for 2016

The Noridian DME Jurisdiction A Supplier Contact Center has created a holiday and training closure schedule that impacts the Supplier Contact Center and Telephone Reopenings. Normal hours of operation are 8 a.m. – 5 p.m. ET.

- View Training Closures
- View Holiday Schedule

## Customer Service Contact Information for Part B Contractors for DME Jurisdiction A Contract Area

When the Jurisdiction A (JA) DME contract transitioned to Noridian on July 1, 2016, the Part B contractors did not change. Please continue to contact Noridian only for DME questions at the single toll-free number, 866-419-9458.

Part B phone call inquiries from the states of Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia should continue to be directed to Novitas Solutions at 1-877-235-8073. Hours available are Monday – Friday: 8 a.m. – 4 p.m. ET.

Part B phone call inquiries from the states of Connecticut, Massachusetts, Maine, New Hampshire, New York, Rhode Island and Vermont should continue to be directed to National Government Services (NGS) at 1-877-869-6504. Hours available are Monday – Friday: 6 a.m. – 7 p.m. ET.

## Incorrect Fax Number Published on Reopening and Redetermination Request Forms

We have identified an error within the Noridian Written Reopening and Written Redetermination forms. Unfortunately, the fax number provided within the forms is incorrect.

### Supplier Action

Requestors should continue to complete the applicable Written Reopening and/or Written Redetermination form; however, please submit the request to fax number 701-277-2425.

No action is required for those suppliers who may have already submitted a Reopening or Redeterminations to the incorrect fax number. This is a Noridian fax number and is being monitored for request processing.

As a reminder, suppliers may check claim status of their Reopening and Redetermination requests via the Interactive Voice Response (IVR) system or via the Noridian Medicare Portal (NMP).

### Noridian Action

Noridian is actively working to update these forms to include the correct fax number. We do apologize for any inconvenience. Thank you for your understanding.

## Noridian Medicare Portal Registration – Steps to Success

Noridian encourages suppliers to register for the Noridian Medicare Portal; https://med.noridianmedicare.com/web/jadme/topics/nmp. Below are tips to help you get through the seven step registration process.

1. Before you start, call the IVR to get your check number and check amount (dollars and cents; no commas please). You will need this information for Step 6. Please do not use your "EFT…" number. That will cause your registration to fail.
2. Steps 1 and 2: In step one will create your account and you will enter your email address. Step 2 is an activity in which you receive an email and click on a link in that email to verify your email address. It must be done within two days. If you missed the email or the timeline, call our office or email japortal@noridian.com. Otherwise, you can't get passed step 4.
3. Step 3 collects privacy questions and answers and then displays your response to you. Ensure you save a copy as you may need this for unlocking accounts or forgotten passwords.
4. If you are in step 4 and it asks you to log out in the lower right hand corner instead of proceeding to the next step, the portal is waiting for you to have selected the hyperlink in the email triggered as part of step 1. If you no longer have the email; call or email us so we may quickly regenerate it for you.
5. Step 5 is where you indicate if you will be a Provider Administrator (grant access for others within your organization) or an End User (conduct inquiries). If you are a small supplier with less than 25 employees, it is important the Provider Administrator indicates "Yes" you are a small provider. When the Provider Administrator completes their registration, they can go into Manage Accounts and change their role to be both a Provider Administrator and End User (known as Dual Role). The Provider Administrator role must register first.
6. Step 6 needs your NPI, PTAN, Tax ID. Suppliers can leave the Trading Partner ID field blank; important to know! Also, the Jurisdiction and the check number and check amount (no commas) is needed. If your check number starts with "EFT…" it is not what we are looking for. You must obtain the check number from the financial menu in the IVR. It often starts with a 9.

Provider Administrators have a two-step approval for each End User. They have to approve both the NPI you will be accessing as well as what functions you can perform in the portal. We are finding that both of the steps are not being followed. Instructions are available on our website; https://med.noridianmedicare.com/web/jadme/topics/nmp/administrator-user-manual#overview.

## Customer Service Telephone Number

Noridian has a single JA DME toll-free number, 866-419-9458, which unifies our customer service areas and simplifies supplier contact. Phone calls are directed by the caller, through our IVR system, to the most appropriate department CSR or to our Interactive Voice Response (IVR). If for any reason your call is misdirected, the CSRs will route you back to the IVR allowing you to select a new department.

View details on the below.

- Noridian Interactive Voice Response (IVR)
- Supplier Contact Center
- Telephone Reopenings

## DMD Articles Now Accessible from the Medical Director Articles Webpage

Looking for one website location where you could find all the articles written collaboratively by all DME MAC Medical Directors? Great news. The "Medical Director Articles" webpage, located within the "Policies" section of our website, is now that stop.

View the 2016 articles which may address local coverage, coding or medical review related billing and claims considerations, and may include any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy.

Please watch for this webpage to grow as previous years and present articles continue to be added.

View the Medical Director Articles webpage.

## Portal Enhancements Implemented July 15, 2016

The Noridian Medicare Portal recently received several enhancements in response to provider/supplier recommendations received through the website satisfaction survey. Some of the changes made available July 15, 2016 improved Provider Administrator's access to oversee 25 Tax Identification Numbers improved the calendar date entry options, corrected a beneficiary name format issue, and improved the appeals submission success rate. The results for the remittance advice and DME financial inquiry were also improved.

The number one recommendation received regarding the Noridian Medicare Portal is to not require the complete Medicare Health Insurance Claim Number and/or to be more lenient with the spelling of the first and last name for eligibility inquiries. We do appreciate the position many providers and suppliers are in and the fact they may not have access to obtain a copy of the Medicare card; however, the requirement surrounding the accuracy of the eligibility data entry elements is driven by the CMS HIPAA Eligibility Transaction System (HETS) criteria.

Please share your recommendations with Noridian by completing the website satisfaction survey each time it is presented in your website navigation or portal experience.

## Noridian Medicare Portal Registration Reminder – Use the IVR

Registration as a Provider Administrator in the Noridian Medicare Portal requires a recent check number and check amount on Step 6. This information should be obtained prior to registration by using the Interactive Voice Response (IVR) Financial Menu at 866-419-9458.

Once on the Main Menu follow the steps below:

- Say/Select:
  - Financial Option
  - Checks
  - Last three checks

Reminders:

- No commas needed in check amount
- Check numbers do not begin with "EFT"
- Check numbers often start with the number 9

More information on Portal registration can be found on the Noridian Medicare Portal page of the Noridian website and referencing Noridian Medicare Portal Registration – Steps to Success article.

## Submit Redeterminations through NMP

Noridian encourages suppliers to use the Noridian Medicare Portal (NMP) to submit redeterminations to streamline office operations.

Take advantage of this self-service tool to eliminate time-consuming faxing or hardcopy mailing. The portal is easy to use and allows suppliers to attach all supporting documentation electronically. Another plus is the real time confirmation number; no more calling the Interactive Voice Response (IVR) to confirm receipt!

The ability to submit redeterminations is just one of many offerings to help suppliers with their Medicare billings.

Visit our Noridian Medicare Portal today to learn more. If a supplier's company has not yet enrolled in the Noridian Medicare Portal, please share this notice with the company official so the organization can learn about all the benefits of joining. The instructions for joining the Noridian Medicare portal are detailed on our website.

## Protecting Patient PHI

### MLN Matters® Number: SE1616

### Provider Types Affected

This MLN Matters® Article is intended for physicians, including physician group practices, that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) using electronic systems to store Personal Health Information (PHI) of their Medicare patients.

### Provider Action Needed

This MLN Matters Special Edition Article reminds physicians of the HIPAA requirement to protect the confidentiality of the PHI of their patients. Recently, the Centers for Medicare & Medicaid Services (CMS) learned of a potential security breach in which someone was offering for sale over 650,000 records of orthopedic patients. Remember that a covered entity must notify the Secretary of Health and Human Services if it discovers a breach of unsecured protected health information. See 45 C.F.R. § 164.408. Also, keep abreast of any issues that your business associates, especially those entities that provide you with hardware and/or software support for your patient electronic health records. Be sure they are required to report any actual or potential security breaches to you, especially threats that compromise patient PHI.

### Background

CMS is providing this information in response to a recent report from the Cyber Health Working Group. This group recently reported the detection of an offer to sell six databases, three of which were databases that appeared to be orthopedic databases. Providers need to be extremely conscious of their systems security, especially with systems that connect to the Internet.

### Additional Information

The report on the advertised sale of patient databases is available at http://hothardware.com/news/hacker-reportedly-infiltrates-three-us-healthcare-companies-offers-650000-patient-records-for-sale.

45 CFR 164.408 is available at https://www.gpo.gov/fdsys/granule/CFR-2011-title45-vol1/CFR-2011-title45-vol1-sec164-408.

Information on reporting breaches of security is available at http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html.

## MLN Connects® Provider eNews – July 7, 2016

MLN Connects® Provider eNews for July 7, 2016

View this edition as a PDF

### News & Announcements

- HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care
- Open Payments Program Posts 2015 Financial Data
- Hospice CAHPS® Exemption for Size Deadline: August 10
- Help Us Improve Access to DMEPOS
- Revised CMS-855R Application: Reassignment of Medicare Benefits
- July Quarterly Provider Update Available
- Rule Gives Providers/Employers Improved Access to Information for Better Patient Care

### Claims, Pricers & Codes

- Modifications to HCPCS Code Set

### Upcoming Events

- SNF Quality Reporting Program Call – July 12

### Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool – New
- Subscribe to the Medicare Learning Network Educational Products and MLN Matters® Electronic Mailing Lists

## MLN Connects® Provider eNews – July 14, 2016

MLN Connects® Provider eNews for July 14, 2016

View this edition as a PDF

**Editor's Note:**

This week's eNews includes a new section on Provider Compliance, highlighting common billing errors. Check out the first message in this series on chiropractic services and learn how to bill Medicare correctly the first time.

### News & Announcements

- New Hospice Report Available July 17
- Clinical Laboratory Fee Schedule Resources
- HIPAA Administrative Simplification Enforcement and Testing Tool
- 2017 QRDA Hospital Quality Reporting Implementation Guide, Schematrons, and Sample File
- Upcoming Medicare Learning Network® Website Redesign

### Provider Compliance

- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

### Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- IRF Quality Reporting Program Provider Training – August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- LTCH Quality Reporting Program Provider Training – August 11

### Medicare Learning Network Publications & Multimedia

- Medicare Billing Certificate Program for Part A Providers WBT – Revised
- Medicare Billing Certificate Programs for Part B Providers WBT – Revised
- Complying With Medicare Signature Requirements Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet – Reminder

## MLN Connects® Provider eNews – July 21, 2016

MLN Connects® Provider eNews for July 21, 2016

View this edition as a PDF

**Editor's Note:**

Our Medicare Learning Network (MLN) website is updated to improve your access to education resources and make finding what you need easier. We hope you will take a look and share your thoughts with us. Learn more in this week's eNews.

### News & Announcements

- Improved Medicare Learning Network Website
- IRF Quality Reporting Program Data Submission Deadline: August 15
- LTCH Quality Reporting Program Data Submission Deadline: August 15
- Hospice Quality Reporting: Reconsideration Period Ends Soon
- SNF Readmission Measure: Top 10 Things You Should Know
- Enhanced Administrative Simplification Website

### Provider Compliance

- CMS Provider Minute: CT Scans Video

### Claims, Pricers & Codes

- Billing for Nursing Visits in Home Health Shortage Areas by an RHC or FQHC

### Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10

### Medicare Learning Network® Publications & Multimedia

- Clinical Labs Call: Audio Recording and Transcript – New
- IMPACT Act Call: Audio Recording and Transcript – New
- Medicare Podiatry Services: Information for FFS Health Care Professionals Fact Sheet – Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet – Revised
- How to Use the National Correct Coding Initiative Tools Booklet – Revised

# MLN Connects® Provider eNews – July 28, 2016

MLN Connects® Provider eNews for July 28, 2016

View this edition as a PDF

## News & Announcements

- Overall Hospital Quality Star Ratings: Evaluation of National Distributions
- Million Hearts® Cardiovascular Disease Risk Reduction Model
- New Payment Models and Rewards for Better Care at Lower Cost
- $42 Billion Saved in Medicare and Medicaid Primarily Through Prevention
- SNF Quarterly Reports Available through Nursing Home Compare
- SNF QRP: Requirements for the FY 2018 Reporting Year Fact Sheet Available
- EHR Incentive Programs: Submit Comments on CY 2017 Hospital OPPS and ASC Proposed Rule by September 6
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

## Provider Compliance

- Home Health Care: Proper Certification Required

## Claims, Pricers & Codes

- July 2016 OPPS Pricer File Update

## Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- Special Open Door Forum: Open Payments Notice to Inform Future Rulemaking – August 2
- Medicare Diabetes Prevention Program Webinar – August 9
- IRF Quality Reporting Program Provider Training – August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Comparative Billing Report on IHC and Special Stains Webinar – August 10
- LTCH Quality Reporting Program Provider Training – August 11
- SNF Quality Reporting Program Provider Training – August 24
- Comparative Billing Report on Modifier 25: Physician Assistant Webinar – August 24
- IMPACT Act: Data Elements and Measure Development Call – August 31

## Medicare Learning Network® Publications & Multimedia

- Protecting Patient Personal Health Information MLN Matters Article – New
- SNF Quality Reporting Program Call: Audio Recording and Transcript – New
- Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody under a Penal Authority Fact Sheet – Revised
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet – Revised
- SNF Billing Reference Fact Sheet – Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool – Reminder
- Suite of Products & Resources for Educators & Students Educational Tool – Reminder
- Suite of Products & Resources for Inpatient Hospitals Educational Tool – Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

## MLN Connects® Provider eNews – August 4, 2016

MLN Connects® Provider eNews for August 4, 2016

View this edition as a PDF

### News & Announcements

- Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017
- SNFs: Final FY 2017 Payment and Policy Changes
- Hospice Benefit: Final FY 2017 Payment and Policy Changes
- IRFs: Final FY 2017 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes
- CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America
- CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States
- First Release of the Overall Hospital Quality Star Rating on Hospital Compare
- Home Health Agencies: New PEPPER Available
- Partial Hospitalization Programs: New PEPPER Available
- Physician Compare: 2014 Quality Data Available
- Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016
- PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs
- Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD
- Administrative Simplification Statutes and Regulations
- ICD-10 Coding Resources
- Vaccines are Not Just for Kids

### Provider Compliance

- Hospital Discharge Day Management Services

### Upcoming Events

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Data Collection on Resources Used in Furnishing Global Services Information Session – August 11
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

### Medicare Learning Network® Publications & Multimedia

- Remittance Advice Information: An Overview Fact Sheet – Reminder
- Medicare Costs at a Glance: 2016 Educational Tool – Revised

## MLN Connects® Provider eNews – August 11, 2016

MLN Connects® Provider eNews for August 11, 2016

View this edition as a PDF

### News & Announcements

- Medicare Announces Participants in Effort to Improve Access, Quality of Care in Rural Areas
- Affordable Care Act Payment Model Continues to Improve Care, Lower Costs
- ESRD QIP PY 2020 Proposed Rule: New Fact Sheet and Video

- CMS to Release a CBR on Positive Airway Pressure Devices, Respiratory Assist Devices and Accessories in August
- TEP on IMPACT Act Quality Measures: Nominations due August 21

### Provider Compliance

- Preventive Services

### Claims, Pricers & Codes

- ICD-10 GEMS for 2017 Available

### Upcoming Events

- ESRD QIP PY 2020 Proposed Rule Call-In Session – August 16
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

### Medicare Learning Network® Publications & Multimedia

- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article – New
- IRFs: Improving Documentation Positively Impacts CERT Web-Based Training Course – New
- Physician Compare Call: Addendum – New
- RHCs HCPCS Reporting Requirement and Billing Updates MLN Matters Article – Revised
- MLN Guided Pathways Provider Specific Medicare Resources Booklet – Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Revised

## MLN Connects® Provider eNews – August 18, 2016

MLN Connects® Provider eNews for August 18, 2016

View this edition as a PDF

### News & Announcements

- CMS Updates Nursing Home Five-Star Quality Ratings
- IMPACT Act Standardized Assessment Data: Comments due August 26
- Medicare Outpatient Observation Notice: Public Comment Period Ends September 1
- Open Payments: Limited Time for Physicians to Dispute 2015 Data
- Programs of All-Inclusive Care for the Elderly
- Administrative Simplification: Adopted Standards and Operating Rules

### Compliance

- Nasal Endoscopy

### Claims, Pricers & Codes

- 2017 ICD-10-CM and ICD-10-PCS Code Updates
- Hospice Claim Adjustments Will Correct Routine Home Care Day Count

### Upcoming Events

- IRF and LTCH Quality Reporting Program: Public Reporting Webinar – August 23
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31

- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15

### Medicare Learning Network® Publications & Multimedia

- Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System MLN Matters Article – New
- ESRD QIP Call: Audio Recording and Transcript – New
- Health Insurance Portability and Accountability Act (HIPAA) EDI Standards Web-Based Training Course – Revised

## MLN Connects® Provider eNews – August 25, 2016

MLN Connects® Provider eNews for August 25, 2016

View this edition as a PDF

### News & Announcements

- ICD-10: Updated Questions and Answers
- IMPACT Act Standardized Assessment Data: Comments due September 12

### Provider Compliance

- Lumbar Spinal Infusion

### Upcoming Events

- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15
- Comparative Billing Report on PAP/RAD and Accessories – September 21

### Medicare Learning Network® Publications & Multimedia

- Next Generation Accountable Care Organization – Implementation MLN Matters® Article – New
- Medicare and Medicaid Basics Booklet – New
- PQRS Call: Audio Recording and Transcript – New
- Global Surgery Information Session: Audio Recording and Transcript – New

## MLN Connects® Provider eNews – September 1, 2016

MLN Connects® Provider eNews for September 1, 2016

View this edition as a PDF

### News & Announcements

- PY 2015 Medicare ACO Results
- EHR Incentive Programs: Submit Comments on Proposed Rule by September 6
- TEP on IMPACT Act Quality Measures: Nominations due September 7
- ESRD QIP Preview Period for PY 2017 Extended to September 30
- New ST PEPPER Available
- ICD-10 Assessment and Maintenance Toolkit
- Are You Required to Comply with Electronic Standards?
- September is Prostate Cancer Awareness Month

## FYI

### Provider Compliance

- Psychiatry and Psychotherapy

### Upcoming Events

- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15
- SNF Value-Based Purchasing Program Call – September 28

### Medicare Learning Network® Publications & Multimedia

- September 2016 Catalog Available
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet – Revised
- Guided Pathways to Medicare Resources Provider Specific Booklet – Revised
- Suite of Products & Resources for Rural Health Providers Educational Tool – Revised
- Medicare Part B Immunization Billing Fact Sheet – Reminder
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet – Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool – Reminder

## APPEALS

### Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-866-419-9458. |
|---|---|
| **What are the hours for Telephone Reopenings?** | Monday through Friday<br>8 a.m. – 5 p.m. ET<br>Further closing information can be found at https://med.noridianmedicare.com/web/jadme/contact/holiday-schedule. |

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-866-419-9458. |
|---|---|
| **What information do I need before I can initiate a Telephone Reopening?** | Before a reopening can be completed, the caller must have **all** of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed.<br>• National Provider Identifier (NPI)<br>• Provider Transaction Access Number (PTAN)<br>• Last five digit of Tax ID Number (TIN)<br>• Supplier name<br>• Beneficiary's Health Insurance Claim Number (HICN)<br>• Beneficiary's first and last name<br>• Beneficiary's date of birth<br>• Date of service (DOS)<br>• Healthcare Common Procedure Coding System (HCPCS) code(s) in question<br>• Corrective action to be taken<br>**Note:** Claims with remark code MA130 can never be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted. |
| **What may I request as a Telephone Reopening?** | The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening. **Note:** This list is not all-inclusive.<br>• Diagnosis code changes or additions<br>• Date of Service (DOS) changes<br>• HCPCS code changes<br>• Certain modifier changes or additions (not an all-inclusive list)<br>• KH • RR • KL<br>• KI • NU • RT<br>• KJ • AU • LT<br>**Note:** If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation. |

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-866-419-9458. |
|---|---|
| **What is not accepted as a Telephone Reopening?** | The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation.<br>• Overutilization denials that require supporting medical records<br>• Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013<br>• Oxygen break in service (BIS) issues<br>• Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher<br>• Overpayments or reductions in payment<br>• Medicare Secondary Payer (MSP) issues<br>• Claims denied for timely filing<br>• Reopenings past one year from the initial determination<br>• Complex Medical Reviews or Additional Documentation Requests<br>• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues<br>• Repair and labor claims<br>• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing<br>• The following modifier changes or additions:<br>• A1 through A9 • GZ • RA<br>• K0 through K4 • KX • RB<br>• GA • EY • TP<br>• GY • KG<br>• Certain HCPCS codes (not all-inclusive list)<br>• A4450 through A44529 • E1028 • J1562<br>• E01949 • J1559 • K0108<br>• E07489 • J1561 • K0462 |
| **What do I do when I have a large amount of corrections?** | • If a supplier has more than 50 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information and provide further direction how to submit the request<br>• If a supplier has a least 10 DOS, the supplier can request a phone appointment for a 30 minute interval. A Telephone Reopenings representative will call the supplier at the designated time and will complete as many reopenings as possible in that time. |
| **Where can I find more information on Telephone Reopenings?** | • Supplier Manual Chapter 13<br>• Appeals Section on the Noridian DME website<br>• IOM Publication 100-04, Chapter 34 |
| **Additional assistance available** | Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Please note, emails containing Protected Health Information (PHI) will be returned as unprocessable. |

# Reopenings Update – Changes to Chapter 34

MLN Matters® Number: MM9639
Related Change Request (CR) #: CR 9639
Related CR Release Date: July 29, 2016
Effective Date: September 30, 2016
Related CR Transmittal #: R3568CP
Implementation Date: September 30, 2016

## Provider Types Affected

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

## Provider Action Needed

Change Request (CR) 9639 provides updates to Chapter 34, Section 10 of the "Medicare Claims Processing Manual" to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory obligations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute. CR9639 includes no policy changes. Make sure that your billing staffs are aware of these updates.

## Background

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within 1 year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within 1 year of the date of the initial determination for any reason, or within 1 to 4 years of the date of the initial determination upon a showing of good cause).

The main clarification in CR9639 is to note that where Medicare medical review staff request documentation from a provider/supplier for a claim, but did not receive it, and issued a denial based on no documentation, the codes used for the denial are as follows:

- **Group Code: CO** – Contractual Obligation
- **Claim Adjustment Reason Code (CARC) 50** – these are non-covered services because this is not deemed a 'medical necessity' by the payer
- **Remittance Advice Remark Code (RARC) M127** – Missing patient medical record for this service).

## Additional Information

The official instruction, CR9639 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3568CP.pdf.

# CEDI Contractor Code Change Notification – Update

When Jurisdiction A and Jurisdiction B transitioned on June 30, 2016, the corresponding contractor codes changed as well. CEDI recommends suppliers work with their software vendors, billing services, and clearinghouses to ensure their software is updated to send the new contractor codes.

## PC-ACE Version 3.0 Upgrade Available

The PC-ACE version 3.0 upgrade is now available for download from the CEDI website under PC-ACE . Start the upgrade by clicking the blue button that reads **PC-ACE Software Downloads**. This will redirect you to the PC-ACE Download Page. Enter your Trading Partner ID, Requestor's Name, ZIP Code, and email Address. Then select the radio button for the "PC-ACE Software – Upgrade version 3.0" and the "Submit Request" button to begin the download process.

The installation code needed for running the upgrade will be sent to the email address entered on the download page.

An **Upgrade Instructions for PC-ACE** document is available on the CEDI website to assist you with upgrading the software.

**Version 3.0 includes the following updates:**

- Updated code list for Claims Adjustment Reason Codes
- Updated code list for Remittance Advice Reason Codes
- Updated code list for HCPCS Codes
- New contractor/payer ID codes for Jurisdiction A and Jurisdiction B

**The new contractor/payer ID codes for Jurisdictions A and B are valid July 1, 2016.**

| Jurisdiction | Payer ID in 277CA prior to evening of June 30, 2016 | Payer ID in 277CA evening of June 30, 2016 and after |
|---|---|---|
| **Jurisdiction A** | 16003 | 16013 |
| **Jurisdiction B** | 17003 | 17013 |
| **Jurisdiction C** | 18003 | 18003 |
| **Jurisdiction D** | 19003 | 19003 |

For more information about the changes, review the PC-ACE Newsletter for PC-ACE Release 3.0 Professional. To view the newsletter, select Release Newsletters and User's Guides located on the CEDI website under PC-ACE Documentation.

If you have any questions or need assistance in downloading the PC-ACE Upgrade from the CEDI website, contact the CEDI Help Desk at ngs.cedihelpdesk@anthem.com or at 866-311-9184.

# Miscellaneous HCPCS Codes Require Additional Information

## Common Electronic Data Interchange (CEDI) Edits

HCPCS codes with a narrative description that indicates miscellaneous, not otherwise classified (NOC), unlisted, or non-specified that is billed to the DME MAC electronically **must include a concise description of the NOC code** in the SV101-7 segment for HIPAA 5010A1 transactions. This segment is limited to 80 characters. If the claim is submitted without this information it will not pass the front-end edits and will be rejected by CEDI with the following reason codes:

- **CSCC A8:** "Acknowledgement/Rejected for relational field in error"
- **CSC 306:** Detailed description of service
- **Edit Reference:** X222.351.2400.SV101-7.020

## CEDI

### Additional Information Required for Adjudication by the DME MAC

Items billed with any HCPCS code with a narrative description that indicates miscellaneous, NOC, unlisted, or non-specified, that is billed to the DME MAC must also include the following in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or on Item 19 of the paper claim form:

- Description of the item or service
- Manufacturer name
- Product name and number
- Supplier Price List (PL) amount
- HCPCS code of related item (if applicable)

Miscellaneous HCPCS codes billed without this information will be denied for incomplete and invalid information and will need to be resubmitted with the missing information included.

Miscellaneous coded products that have a specific HCPCS code must not be billed with a miscellaneous HCPCS code for that item. Inappropriate billing of miscellaneous HCPCS codes can result in a claim return/reject or denial of the HCPCS code for invalid coding.

Questions concerning HCPCS code classifications should be directed to the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail by completing the DME PDAC Contact Form located on the PDAC website at https://www.dmepdac.com/.

Refer to the applicable Local Coverage Determinations (LCDs) and related Policy Articles for additional information on requirements for miscellaneous HCPCS codes.

## CERT

# CERT Documentation

This article is to remind suppliers they must comply with requests from the CERT Documentation Contractor for medical records needed for the Comprehensive Error Rate Testing program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is (240) 568-6222.

Mail all requested documentation to:

- **CERT Documentation Office**
  Attn: CID #:xxxxxx
  9090 Junction Drive, Suite 9
  Annapolis Junction, MD 20701

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at (301) 957-2380 with questions regarding specific documentation to submit.

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian as the services for which there is no documentation are interpreted as services not rendered.

## CERT Contact Information

To submit a question related to Comprehensive Error Rate Testing (CERT) to Noridian DME Medicare for Jurisdiction A CERT claims, suppliers may either call Noridian's CERT team or send an email. Both inquiry types are responded to within two business days. For more information, see the complete article here.

## CERT MAC Improper Payment Rates for 2014 and 2015

Noridian Healthcare Solutions is pleased to announce that the CMS recently published the Comprehensive Error Rate Testing (CERT) 2014 and 2015 improper payment rates by Medicare Administrative Contractor (MAC) Jurisdictions. Visit: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/MedicareFFSJurisdictionErrorRateContributionData.html to view interactive maps and learn more about: improper payments; error rate scoring; and corrective actions.

**The national projected error rates have been provided below.**

### 2014

| Claim Type | Projected Improper Payment | Improper Payment Rate |
|---|---|---|
| **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)** | $5.1 | 53.1% |
| **Part A (Total)** | $29.6 | 11.4% |
| Part A (Excluding IPPS) | $19.2 | 13.1% |
| Part A (Hospital IPPS) | $10.4 | 9.2% |
| **Part B** | $11.0 | 12.1% |

### 2015

| Claim Type | Projected Improper Payment | Improper Payment Rate |
|---|---|---|
| **DMEPOS** | $3.2 | 39.9% |
| **Part A (Total)** | $28.7 | 11.0% |
| Part A (Excluding IPPS) | $21.7 | 14.7% |
| Part A (Hospital IPPS) | $7.0 | 6.2% |
| **Part B** | $11.5 | 12.7% |

Note that the figures in the above tables have been adjusted for A to B rebilling and some totals may not appear to properly average due to rounding. Dollars displayed are in billions.

As the CMS stated in their July 21, 2016 publication, *Medicare Fee For Service (FFS) Jurisdiction Error Rate Contribution Data*, "Provider compliance is fundamental to reducing improper payment rates. Both the CMS and MACs are engaged in a continuing process to identify and execute new and promising practices to improve provider compliance."

## CERT

Noridian Healthcare Solutions reminds providers and suppliers that they have a direct impact on the improper payment rates. The leading error category, as published in the *Medicare Fee-for-Service 2015 Improper Payments Report*, is Insufficient Documentation. Providers are encouraged to review intake processes and Local Coverage Determinations to ensure they have proper documentation on file for the items being billed.

To receive additional information on the educational products and services Noridian Healthcare Solutions offers, please contact the appropriate email addresses below.

- **Part A:** CERTPartAQuestion@noridian.com
- **Part B:** CERTQuestion@noridian.com
- **JD DME:** JDDMECERT@noridian.com
- **JA DME:** JADMECERT@noridian.com

## CODING

### Correction of Remark Code Information

**MLN Matters® Number: MM9641**
**Related Change Request (CR) #: CR 9641**
**Related CR Release Date: July 15, 2016**
**Effective Date: October 17, 2016**
**Related CR Transmittal #: R3560CP**
**Implementation Date: October 17, 2016**

#### Provider Types Affected

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

#### What You Need to Know

Change Request (CR) 9641 updates the "Medicare Claims Processing Manual," Chapter 30, to make corrections to Remittance Advice Codes and general punctuation and grammar corrections. All Remittance Advice messaging must follow a prescribed set of rules. Specifically, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may only be used in specified combinations laid out by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), the designated Standards Development Organization (SDO). The CARC and RARC code sets are available via the Washington Publishing Company (WPC) at http://www.wpc-edi.com/Reference.

#### Additional Information

The official instruction, CR9641, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3560CP.pdf.

# HPTC – October 2016 Code Set Update

**MLN Matters® Number: MM9659**
**Related Change Request (CR) #: CR 9659**
**Related CR Release Date: August 26, 2016**
**Effective Date: October 1, 2016**
**Related CR Transmittal #: R3597CP**
**Implementation Date: January 3, 2017, except some MACs may implement on October 1, 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

CR9659 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference file. MACs that have the capability to do so will implement the October 2016 HPTC set as early as October 1, 2016, for claims received on or after October 1, 2016. All MACs will implement the HPTC set by January 3, 2017.

## 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.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR9659 implements the NUCC HPTC code set that is effective on October 1, 2016, and instructs MACs to obtain the most recent HPTC set at http://www.wpc-edi.com/codes and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC code set online, you can identify revisions made since the last release by the color code:

- New items are green
- Modified items are orange, and
- Inactive items are red

## Additional Information

The official instruction, CR 9659 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3597CP.pdf.

## HCPCS Codes for SNF CB – 2017 Annual Update

**MLN Matters® Number: MM9735**
**Related Change Request (CR) #: CR 9735**
**Related CR Release Date: August 26, 2017**
**Effective Date: January 1, 2017**
**Related CR Transmittal #: R3603CP**
**Implementation Date: January 3, 2017**

### Provider Types Affected

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

### Provider Action Needed

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 9735 could impact your payments.

CR9735 provides the 2017 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for SNF Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2016, the new code files for Part B processing, and the new Excel and PDF files for Part A processing, will be available at http://www.cms.gov/SNFConsolidatedBilling and will become effective on January 1, 2017.

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

### Background

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

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the Chapter 6, Section 20.6 (Part A) and Section 110.4.1 (Part B) of the "Medicare Claims Processing Manual," available for download at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf.

### Additional Information

The official instruction, CR9735, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3603CP.pdf.

## Correct Coding – HCPCS Coding Recommendations from Non-Medicare Sources

### DME MAC Joint Publication

Correct Healthcare Common Procedure Coding System (HCPCS) code selection for a product is an essential element for claims payment. Use of the appropriate HCPCS code assures that accurate processing can be accomplished resulting in a proper claim determination and reimbursement. Conversely, incorrect coding may result in improper payment necessitating recoupment and possible false claim actions. Thus, it is important that all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers take steps to ensure that claims are correctly coded.

## Background

The HCPCS is a standardized set of codes used for billing items and services to all payers, including Medicare and Medicaid. The HCPCS is divided into two principal subsystems, referred to as level I and level II. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services, dental services, and procedures furnished by physicians and other health care professionals.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and DMEPOS when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.

In October of 2003, the Secretary of Health and Human Services (HHS) delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR 414.40 (a), CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. To accomplish the task of maintaining the Level II HCPCS system, CMS established a workgroup comprised of representatives of the major components of CMS, CMS contractors, as well as other participants from pertinent Federal agencies, and representatives of state Medicaid agencies, the private insurance sector and the Department of Veteran's Affairs.

Each payer separately develops their own coverage criteria, coding guidelines, and fees for HCPCS Level II codes.

## Coding Guidelines for Medicare

For Medicare claims, only CMS and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have authority to establish HCPCS Level II Coding Guidelines. The CMS Internet Only Manual (IOM), Publication 100-08, Program Integrity Manual (PIM), Chapter 3, Section 3.3.B and Section 3.6.2.4 instruct, in relevant part:

> [A]n item/service is correctly coded when it meets all the coding guidelines listed in … CMS HCPCS policy or guideline requirements, LCDs, or MAC articles.

The DME MACs and the Pricing, Data Analysis, and Coding (PDAC) contractor are responsible for assigning individual DMEPOS products to HCPCS code categories for billing Medicare. Manufacturers and other entities do not have similar authority to assign their own code determinations to specific products. Often these unofficial and unauthorized coding assignments are described as "recommendations". DMEPOS suppliers are cautioned that such recommendations have no official status and, in the event of a claim review, may result in an incorrect coding claim denial. In addition, these unofficial coding recommendations are not helpful in defense of an incorrect coding claim denial during the appeals process.

When a product has been formally reviewed by the DME MACs or PDAC, the manufacturer is provided with a letter informing them of the correct coding to be used for Medicare billing purposes. We encourage DMEPOS suppliers only to accept coding information from manufacturers and others when the product has been officially coded and a correct coding letter has been issued or the specific product is listed on DMECS.

The DME MACs publish coding guidelines in LCD related Policy Articles and in correct coding bulletins. The information in these publications is considered the authoritative coding instructions for Medicare billing purposes as described in PIM Chapter 3.

PDAC maintains product listings for many HCPCS codes on the website. Select, "Durable Medical Equipment Coding System (DMECS)" to search for HCPCS codes and associated product lists. Not every HCPCS code has a product classification list; but reviewed products are added to the listings for each code as coding determinations are completed. For Medicare claim purposes, this product classification listing is accepted as evidence of correct coding.

### Correct Coding of Claims

Each supplier is ultimately responsible for the HCPCS code(s) they select to bill for the items provided. Resources like code determinations letters and DMECS are useful but many products have not been reviewed. For these un-reviewed products, each supplier must use their best judgment in selecting HCPCS codes for billing. Here are some tips that will help:

- Check the PDAC Product Classification Lists on DMECS. Although not every HCPCS code has an associated product list, many of the most commonly used codes do.
- Check the DME MAC publications for coding bulletins and coding guidelines related to products and HCPCS codes for specific information on the item of interest.
- Refer to the "long" code narrative. All codes have short and long descriptors. The long descriptor often provides more detail regarding the requirements for the code. Select the code with the descriptor that most closely describes the product.
- Most code narratives are written broadly to be all-inclusive. You may not find a specific code that perfectly matches a product. Use the code that most closely describes the item rather than a NOC (not otherwise classified) or miscellaneous code.
- Local Coverage Determination related Policy Articles often have additional information in the Coding Guidelines section. Coding guidelines provide additional information on the characteristics of products that meet a specific HCPCS code.
- Remember that price and fees are NOT part of correct coding. Selecting a code based upon the fee schedule almost always results in an incorrect coding determination. HCPCS codes describe the product not the price.
- Check with the PDAC. The PDAC Contact Center can provide information that will assist you in code selection. This assistance, however, is NOT considered a formal product review. The advice provided is not an official code determination. Items are not added to the DMECS Product Classification List based on a query to the PDAC Contact Center.
- Request that manufacturers submit their products for coding. Although some HCPCS codes require mandatory product review in order to use the code, for most codes product review is voluntary. Many manufacturers are responsive to their customer' requests for verified HCPCS coding.

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

## Correct Coding and Coverage – Oral Suspensions used in the Treatment of Oral Mucosal Injuries

### Joint DME MAC Publication

In recent years, several products have come to market for use by beneficiaries with oral mucosal injuries. These products, Mugard Mucoadhesive (AMAG Pharmaceuticals, Inc.), Gelclair (DARA BioSciences Inc.), and similar products claim to adhere to the injured mucosal surface providing protection. These oral suspensions are used in the treatment of oral mucosal injuries caused by a variety of underlying illnesses and treatments. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) Medical Directors have evaluated these products for coverage.

Medicare is a defined benefit program. In order for any item to be eligible for payment, the item must first be eligible for inclusion into one of the statutorily established benefit categories. The Medicare Surgical Dressings Benefit provides the definition of covered dressings that are eligible for dressing reimbursement. CMS Internet Only Manual (IOM), Publication 100-02, *Benefit Policy Manual*, Chapter 15, Section 100 says, in relevant part:

> Surgical dressings are **limited to primary and secondary dressings** required for the treatment of a wound…
>
> Primary dressings are therapeutic or protective coverings applied directly to **wounds or lesions either on the skin or caused by an opening to the skin**. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. (Emphasis added)

This benefit limits coverage to wounds of the skin. Treatments used for injuries to the oral mucosa are not eligible for coverage under this benefit as oral mucosa is not skin. It is a different tissue type and thus is excluded from this benefit.

Although these products may serve a beneficial purpose in the treatment of oral mucosal injuries, there is no coverage available under the Surgical Dressings benefit for these items. There is no other benefit category under which Medicare coverage might be possible. Claims submitted to the DME MACs for these products must use HCPCS code:

- **A9270** – NON-COVERED ITEM OR SERVICE

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 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

## Correct Coding – Cantilever Type Armrest

### DME MAC Joint Publication

A cantilever or flip up armrest is a non-detachable armrest that pivots to move the armrest away from the patient in a fashion analogous to a swing-away armrest. There is no specific HCPCS code for this item. These types of movable armrests are included in the Basic Equipment Package for power wheelchairs and power seating systems. To bill this type of armrest separately at initial issue, the correct HCPCS code is:

- **A9900** – MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE

To bill this type of armrest as a repair to a covered wheelchair or seating system, the correct HCPCS code is:

- **K0108** – WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED *

In this repair billing scenario code K0108 includes all parts necessary to replace the armrest. As a repair, K0108 must be used in combination with the appropriate repair modifier (RB – REPLACEMENT OF A PART OF DME FURNISHED AS PART OF A REPAIR).

If the entire wheelchair or seating system is being replaced, there is no separate payment for a cantilever armrest, as described above. Use HCPCS code A9900 for separate billing of the armrest in this scenario.

**Note:** When a NOC (not otherwise classified/specified) code is billed the claim must be accompanied by:

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

Refer to the Wheelchair Options/Accessories LCD and related Policy Article for additional information about coverage, documentation, and coding.

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

# Correct Coding – Eclipse™ Vaginal Insert system (Pelvalon, Inc.)

## Joint DME MAC Article

The Eclipse™ Vaginal Insert system (Pelvalon, Inc.) is an inflatable vaginal insert designed to exert pressure on the rectal vault to treat fecal incontinence. FDA approval for marketing under this indication was granted on February 12, 2015. According to the manufacturer, the Eclipse™ system consists of a vaginal insert and a pressure-regulated pump. The insert, consisting of a silicone-covered stainless steel base and a posteriorly directed balloon, is placed in the vaginal vault and inflated. The balloon is deflated via the pump when the user needs to have a bowel movement.

The insert must first be fitted in the physician's office. This procedure is billed under a CPT code that is all-inclusive. Services rendered in a physician office and billed under a CPT code are not within the jurisdiction of the DME MACs. Items provided as part of that service are considered incident to the service and are not separately billable to the DME MACs.

The DME MACs have determined that the Eclipse™ Vaginal Insert system meets the requirements of the Prosthetic Devices benefit (Social Security Act §1861(s)(9)). To meet this benefit, the device must replace all or part of a non-functioning body member. There is currently no HCPCS code assigned to the Eclipse™ system. The DME MACs have determined that this item must be coded as:

- **A4335** – INCONTINENCE SUPPLY, MISCELLANEOUS

Suppliers are reminded that items billed with a miscellaneous HCPCS code require the following documentation to be submitted with the claim:

- Description of the item or service
- Manufacturer name
- Product name and number

Miscellaneous HCPCS codes billed without this information will be rejected for missing documentation and will need to be resubmitted with the missing information.

This information will be added to the Bowel Management Devices Local Coverage Determination and related Policy Article in an upcoming revision.

Questions concerning HCPCS code classifications should be directed to 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 located on the PDAC website www.dmepdac.com/dmecs.

# Correct Coding and Coverage – Braces Constructed Primarily of Elastic or Other Fabric Materials

## DME MAC Joint Publication

**Revised:** July 28, 2016

**Originally posted:** January 1, 2009

The 2009 PDAC Article "Elastic Garments – Noncovered" is revised to provide a more comprehensive discussion of statutory benefit category requirements and HCPCS coding guidelines applicable to these items.

## Benefit Category

All orthoses are covered under the Medicare Braces Benefit (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Items that are not sufficiently rigid to be capable of providing the necessary immobilization or support to the body part for which it is designed do not meet the statutory definition of the Braces Benefit. Therefore, claims for these items will be denied as noncovered, no benefit category.

The following spinal orthoses HCPCS codes contain both elastic and inelastic items in the same HCPCS code. The applicable codes are:

- L0450 – TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
- L0454 – TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
- L0455 – TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
- L0621 – SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
- L0625 – LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, OFF-THE-SHELF
- L0628 – LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

There are special HCPCS modifier coding instructions that must be used to separate items made of elastic and inelastic materials. (see below)

## Coding Guidelines

For the spinal garment codes listed above (L0450, L0454, L0455, L0621, L0625, L0628), effective for claims with dates of service on or after April 1, 2009:

- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) must add the GY modifier to the code.
- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) that contain stays and/or panels must add the GY modifier to the code.
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed must add the CG modifier to the code.
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed and that have stays and/or panels capable of providing the required immobilization or support to the body part for which it is designed must add the CG modifier to the code.
- Items that are not capable of providing the necessary immobilization or support to the body part for which it is designed (regardless of materials) must add the GY modifier to the code.

If the CG or GY modifier is not used with one of the preceding HCPCS codes, the claim will be rejected as incorrect coding.

## CODING

For items where the HCPCS code specifies "elastic" use the code that is applicable.

For items where the HCPCS code does not specify elastic (other than the spinal codes listed above), the following guidelines apply:

- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) must be coded as A4466 (GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH).
- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®]) (not all-inclusive)) that contain stays and/or panels must be coded as A4466 (GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH).
- Items that are primarily constructed of inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed must be coded using the applicable specific HCPCS code for the type of product. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used. Refer to the long code narrative and any relevant coding guideline for the criteria applicable for each HCPCS code.
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed that have stays and/or panels capable of providing the required immobilization or support to the body part for which it is designed must be coded using the applicable specific HCPCS code for the type of product. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used. Refer to the long code narrative and any relevant coding guideline for the criteria applicable for each HCPCS code.
- Items that are not capable of providing the necessary immobilization or support to the body part for which it is designed (regardless of materials) must be coded using A9270 (NONCOVERED ITEM OR SERVICE).

This information will be incorporated into a future revision of the Ankle-Foot/Knee-Ankle-Foot Orthoses (AFO/KAFO), Knee Orthoses (KO), and Spinal Orthoses (LSO/TLSO) LCDs and related Policy Articles.

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.

## COMPETITIVE BIDDING

### DMEPOS CBP: Additional Instructions for the Implementation of Round 2 Recompete of the DMEPOS CBP Program and National Mail Order Recompete – Third Revision

**MLN Matters® Number: MM9579 Revised**
**Related Change Request (CR) #: CR 9579**
**Related CR Release Date: August 17, 2016**
**Effective Date: October 1, 2016**
**Related CR Transmittal #: R3593CP**
**Implementation Date: October 3, 2016**

This article was revised on August 17, 2016, due to a revised Change Request (CR). That CR changed a business requirement (BR) for payments. The BR is included in this article as a note on the last page. The transmittal number, CR release date and link to the transmittal also changed. All other information is unchanged.

## Provider Types Affected

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

## Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 9579 to provide instructions detailing changes to the DMEPOS Competitive Bidding Program (CBP) regarding the clarification of the RB modifier for Medicare payment for the repair of parts furnished in Competitive Bidding Areas (CBAs) and clarification of grandfathering instructions for rentals of accessories and supplies.

## Background

The purpose of CR9579 is to provide instructions for implementing the following clarifications to the DMEPOS CBP program.

**Clarification of Medicare Payment for Repair Parts Furnished in Competitive Bidding Areas**

Under the Medicare DMEPOS CBP, repairs of beneficiary-owned items may be performed by any Medicare-enrolled supplier. Repairs to certain, medically necessary beneficiary-owned equipment are covered when necessary to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and is paid according to Medicare's general payment rules.

CR8181 (see related article MM8181) implemented claims billing and processing instructions for wheelchair accessories furnished for use with non-competitively bid wheelchair base units for beneficiaries who permanently reside in competitive bid areas. This instruction implemented use of the KY modifier in certain instances. This instruction clarifies how payment is made for repair parts furnished in competitive bidding areas.

In accordance with 42 CFR 414.408(k)(1)(iii), payments for repair parts that are described by HCPCS codes for competitive bidding items and are furnished in CBAs are made based on the single payment amount established for the HCPCS code. Payment for such repair parts that are furnished for use in repairing base equipment that are not competitive bidding items in the area is made in accordance with 42 CFR 414.408(k)(1)(ii), which provides that payment for the part is made based on the MAC's consideration of the item under 42 CFR 414.210(e). When making payment determinations for parts described by HCPCS codes for competitive bidding items furnished for use in repairing base equipment that are not competitive bidding items, MACs have discretion to use the single payment amounts for the item in establishing the Medicare allowed amount for the repair part.

The regulations at 414.210(e) also provide that payment for repair parts is made on a lump sum purchase basis. **Therefore, effective October 1, 2016**, all repair part claims billed with the RB modifier, whether within or outside a CBA, whether described by a HCPCS code that is a competitive bidding item or not, and whether described by a code for miscellaneous (not otherwise classified or specified) items or not, shall be paid on a lump sum purchase basis.

Additionally, CMS has become aware that wheelchair claims are being submitted with the following modifier combinations: the RB and KY; RB and KE; and RB and RR modifiers. If the claim is for a repair part, these three following combinations are not valid, and the claim will be returned as unprocessable.

**Clarification of Grandfathering instructions**

Under the Medicare DMEPOS CBP, a beneficiary who obtains competitive bidding items in a designated CBA must obtain these items from a contract supplier, unless an exception applies. One exception is that a beneficiary may continue to obtain a DME rental item(s) from a non-contract supplier if the beneficiary was receiving the rented item(s) from the non-contract supplier when the CBP took effect in the CBA. Such non-contract supplier would be considered a "grandfathered supplier" with respect to such rented item and such beneficiary for the remainder of the period during which rental payments are made (for example, for the remainder of the 13-month period of continuous use for a capped rental item). An additional exception is that a beneficiary, who continues to obtain a rented, grandfathered competitive bidding item from a non-contract, grandfathered supplier, may also obtain certain covered accessories or supplies furnished for use with such rented "grandfathered" equipment from the same non-contract, grandfathered supplier for the remainder of the period during which rental payments are made (for example, for the remainder of the 13-month period of continuous use for a capped rental item).

For rented, grandfathered equipment in the capped rental payment class (for example, a Continuous Positive Airway Pressure (CPAP) device or manual wheelchair), after the rental payment cap for the grandfathered equipment and after the rental payment cap on the accessory (when applicable, such as, elevating leg rests) is reached, the beneficiary must obtain covered accessories and supplies (for example, CPAP masks) from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies once the rental payment cap on the grandfathered equipment is reached, with the exception of completing the rental period for accessories when the first rental month began during the rental period for the grandfathered equipment (for example, the addition of elevating leg rests during the third rental month for a grandfathered manual wheelchair). For rented, grandfathered equipment in the inexpensive or routinely purchased payment class, after the total payments for the rented, grandfathered equipment (such as a folding walker) reach the purchase fee schedule amount for the grandfathered equipment, and after the rental payment cap on the accessory is reached (when applicable), the beneficiary must obtain covered accessories (for example. seat attachment) and supplies from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies once the rental payment cap on the equipment is reached, with the exception of completing the rental period for accessories when the first rental month began during the rental period for the grandfathered equipment.

In all cases, payment for covered accessories and supplies used in conjunction with a grandfathered item is based on the single payment amount calculated for the item for the CBA in which the beneficiary maintains a permanent residence.

In summary, Medicare payment may be made to a non-contract, grandfathered supplier for furnishing certain covered accessories or supplies furnished for use with rented, grandfathered equipment, provided the non-contract supplier is also furnishing the rented equipment on a grandfathered basis. Once rental payments for the grandfathered equipment have ended, Medicare payment will no longer be made to a non-contract, grandfathered supplier for furnishing accessories or supplies with the exception of completing the rental period for rented accessories.

The following instruction was added to CR 9579 on August 17, 2016: Payments will be allowed at the fee schedule amount for accessory rental items (modifier RR) submitted with modifier KY by non-contract suppliers that are furnished for use with non-bid wheelchair bases. This applies to any wheelchair accessory rental item that has the Business Rule G on the CBIC HCPCS file.

### Additional Information

The official instruction, CR9579 issued to your MAC regarding this change is available at http://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/R3593CP.pdf.

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-LearningNetwork-MLN/MLNMattersArticles/index.html under – How Does It Work.

You may review MM 8181, "Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) National Competitive Bidding (NCB): Using the "KY" Modifier to Bill for Accessories for Non-NCB Wheelchair Base Units" (Transmittal 1184, February 8, 2013) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8181.pdf.

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

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

# DMEPOS CBP – Quarterly Update October 2016

**MLN Matters® Number: MM9701**
**Related Change Request (CR) #: CR 9701**
**Related CR Release Date: July 1, 2016**
**Effective Date: October 1, 2016**
**Related CR Transmittal #: R3554CP**
**Implementation October 3, 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) 9701 provides the October 2016 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. The Centers for Medicare & Medicaid Services (CMS) issued CR9701 to provide the DMEPOS Competitive Bidding Program (CBP) October 2016 quarterly update.

CR9701 provides specific instructions to your Durable Medical Equipment (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 available on the DMEPOS Competitive Bidding Program (CBP) website. At that site, click on the quarterly updates link in the left of the page.

## Background

The DMEPOS CBP was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 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, Medicare conducts a competition among suppliers who operate in a particular Competitive Bidding Area. Suppliers must 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, CR9701 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3554CP.pdf.

The DMEPOS CBP site (http://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Home) includes information on all rounds of the CBP, including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

## DOCUMENTATION

### Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

**Source:** Internet Only Manual, Publication 100-8, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

## EDUCATIONAL

### Noridian DME Outreach and Education Welcomes Jurisdiction A Suppliers

Noridian DME Outreach and Education team welcomes all suppliers within Jurisdiction A (JA). The Outreach and Education Representatives educate Medicare suppliers about the Medicare program fundamentals, policies and procedures, new Medicare initiatives and any significant Medicare program changes. To best assist our supplier community, a variety of Medicare strategies and methods are offered. Please view all upcoming educational events on the Education & Outreach Schedule of Events webpage. Such events available may include Web-based Workshops, In-person Seminars, Live Online Q&A Sessions and Ask the Contractor Teleconferences. To better get to know the JA supplier community, In-Person Seminars will be scheduled in late summer/early fall. More information will be published as these become available.

Noridian's model for education relies on subject matter experts, allowing suppliers who provide multiple products to interact with many of us. While Education Representatives can provide education for the supplier community on any topic, the subject matter expert model allows Noridian representatives to be fully knowledgeable about a limited number of policies. We find this specialization beneficial in the one-on-one web-based meetings because each representative has in-depth experience with our current assigned policies.

We look forward to working with each supplier and encourage all suppliers to visit the Education & Outreach section of our website for more information.

## Electronic Funds Transfer (EFT)

A new Form CMS-588 (5/10) Electronic Funds Transfer (EFT) Authorization Agreements was not required to be submitted during the transition from NHIC to Noridian.

As part of the normal enrollment or revalidation process, Noridian will continue to review suppliers file and confirm they are set up with electronic payments and that they are using the most recent version of the new Form CMS-588 (09/13). If we discover that suppliers are not set up or an older version of the Form CMS-588 is being used, we will request a new Form CMS-588 (9/13).

View the Electronic Funds Transfer (EFT) webpage for more details.

## Timely Reporting of Provider Enrollment Information Changes

### MLN Matters® Number: SE1617

### Provider Types Affected

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

### Provider Action Needed

Failure to comply with the requirements to report changes in your Medicare enrollment information could result in the revocation of your Medicare billing privileges. This article does not establish any new or revised policy, but serves as a reminder to comply with existing policy. MLN Matters® Article SE1617 reinforces the importance of the timely reporting of changes in your Medicare enrollment information. Comply with the reporting requirements for changes in your enrollment information and avoid disruption of your Medicare claims payments.

### Background

In accordance with 42 Code of Federal Regulations (CFR) Section 424.516(d), all physicians, non-physician practitioners (for example, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals) and physician and non-physician practitioner organizations must report the following changes in their enrollment information to your MAC via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or the CMS 855 paper enrollment application within 30 days of the change:

- A change in ownership
- An adverse legal action, or
- A change in practice location.

You must report all other changes to your MAC within 90 days of the change.

If you are a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), you must report any changes in information supplied on the enrollment application within 30 days of the change to the National Supplier Clearinghouse (NSC) (42 CFR §424.57(c)(2)).

Independent Diagnostic Testing Facilities must report changes in ownership, location, general supervision, and adverse legal actions to your MAC either online, or via the appropriate CMS-855 form, within 30 calendar days of the change. You must report all other changes to your enrollment information within 90 days of the change (42 CFR §410.33(g)(2).

All providers and suppliers not previously identified must report any changes of ownership, including a change in an authorized or delegated official, within 30 days; and all other informational changes within 90 days (42 CFR §424.516(e)).

**It is very important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.**

## Enteral Nutrition (HCPCS B4035) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code:

- **B4035:** Enteral feeding supply kit; Pump fed, per day, includes but not limited to feeding/flashing syringe, administration set tubing, dressings, tape

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Enteral Nutrition (HCPCS B4035) Notification of Service Specific Prepayment Targeted Review.

## Parenteral Nutrition (HCPCS B4197, B4199) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS codes:

- **B4197:** Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength 74 to 100 grams of protein – premix
- **B4199:** Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength over 100 grams of protein – premix

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Parenteral Nutrition (HCPCS B4197, B4199) Notification of Service Specific Prepayment Targeted Review.

# FORMS

## Certificates of Medical Necessity and DME Information Forms

### Joint DME MAC Publication

Recently the DME MACs have received inquiries about expired Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs). These forms must be periodically reauthorized. The Final Notice extending the use of all CMNs and DIFs was published in the *Federal Register* on May 11, 2016, and all forms have been extended through 2019.

## GLUCOSE MONITORS

### Glucose Monitors (HCPCS A4253) Notification of Documentation Compliance Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a documentation compliance review of the following HCPCS code(s):

- **A4253:** Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips

A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Glucose Monitors (HCPCS A4253) Notification of Documentation Compliance Review.

## HOSPITAL BEDS

### Hospital Beds (HCPCS E0260) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code:

- **E0260:** Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Hospital Beds (HCPCS E0260) Notification of Service Specific Prepayment Targeted Review.

## IMMUNOSUPPRESSIVE DRUGS

### Immunosuppressive Drugs (HCPCS J7507, J7517, J7518) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS codes:

- **J7507:** Tacrolimus, Immediate Release, Oral, 1 mg
- **J7517:** Mycophenolate Mofetil, Oral, 250 mg
- **J7518:** Mycophenolic Acid, Oral, 180 mg

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Immunosuppressive Drugs (HCPCS J7507, J7517, J7518) Notification of Service Specific Prepayment Targeted Review.

## LCD and Policy Article Revisions Summary for July 7, 2016

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

**Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)**
**LCD**
**Revision Effective Date: 07/01/2016**

HCPCS CODES:

Added: HCPCS code Q9981

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language to add New order requirements, and Correct coding instructions; revised Proof of delivery instructions (Effective 04/28/16)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: HCPCS Q9981 for billing instructions

**Policy Article**
**Revision Effective Date: 07/01/2016**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Covered 3-drug combination regimen with Q9981

CODING GUIDELINES:

Added: HCPCS Q9981 for billing Rolapitant effective on or after 07/01/2016
Added: End date for HCPCS Q0181
Added: HCPCS Q9981 to coding instructions

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

## LCD Revisions Summary for August 4, 2016

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) that has been revised and posted. The policy included is Knee Orthoses. Please review the entire LCD for complete information.

**Knee Orthoses LCD**
**Revision Effective Date: 07/01/2016**

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Replaced: ICD-10 Code M21.869 with Q68.2 in Group 5 – Effective 10/01/2015
DOCUMENTATION REQUIREMENTS:
Revised: Standard language – Start Date instructions – Effective 04/28/2016

**Note:** The information contained in this article is only a summary of revisions to the LCD. For complete information you must review the LCD.

## LCD and Policy Article Revisions Summary for August 11, 2016

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Bowel Management Devices, Nebulizers and Oral Anti-Cancer Drugs. Please review the entire LCD and related PA for complete information.

**Bowel Management Devices**
**LCD**
**Revision Effective Date 07/01/2016**

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

Added: Vaginal inserts and accessories information (Effective date 02/12/2015)

HCPCS MODIFIERS:

Deleted: GA, GZ, GY modifiers

DOCUMENTATION REQUIREMENTS:

Revised: Standard documentation language to Orders, revise Proof of delivery instructions, and add Correct coding instructions (Effective date 04/28/2016)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Deleted: GA, GZ, GY modifiers section

**Policy Article**
**Revision Effective Date: 07/01/2016**

CODING GUIDELINES:

Added: Coding guideline definition of vaginal insert (Effective date

02/12/2015)

**Nebulizers**
**LCD**
**Revision Effective Date: 07/01/2016**

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

Revised: Standard documentation language – ACA requirements – Effective 04/28/16

Added: A7007 and A7017 related accessories table for E0572

Added: Denial verbiage for JW Modifier when coverage criteria not met – Effective 01/01/17

HCPCS MODIFIERS:

Added: JW Modifier – Effective January 1, 2017

DOCUMENTATION REQUIREMENTS:

Revised: Standard documentation language for orders and ACA requirements, added New order requirements, and Correct coding instructions; revised Refill requirements to change "should" to "must", revised Proof of delivery instructions – Effective 04/28/16

Added: JW Modifier instructions – Effective January 1, 2017

**Policy Article**
**Revision Effective Date: 07/01/2016**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Standard documentation language-adding Statutory Prescription (Order) Requirements, revising ACA requirements – Effective 04/28/16

Revised: Dispensing fee date example from 04/20 to 04/10

**Oral Anticancer Drugs**
**LCD**
**Revision Effective Date: 07/01/2016**

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

Revised: Standard Documentation language for Refill Requirements (Effective 04/28/16)

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language in orders, added New order requirements; revised language in Refill documentation, Proof of delivery instructions, and added Correct coding instructions (Effective 04/28/16)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

**Updated: "should" to "must" for electronic claim narrative requirement**

**Policy Article**
**Revision Effective Date: 10/01/2015:**

Covered ICD-10 Codes:

Added: C7B.00, C7B.01, C7B.02, C7B.03, C7B.04 and C7B.09 to Groups 2 and 8 (Effective 10/01/2015)

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 LCDs and/or Policy Articles.

## LCD and Policy Article Revisions Summary for August 18, 2016

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Automatic External Defibrillators, Heating Pads and Heat Lamps, High Frequency Chest Wall Oscillations Devices. Please review the entire LCD and related PA for complete information.

**Automatic External Defibrillators**
**LCD**
**Revision Effective Date: 07/01/2016**

DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for orders, and Proof of delivery instructions, added New order requirements, and Correct coding instructions; (Effective 04/28/2016)

**Policy Article**
**Revision Effective Date: 07/01/2016**

Updated: Title to remove effective date

**Heating Pads and Heat Lamps**
**LCD**
**Revision Effective Date: 07/01/2016**

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation language – ACA order requirements – Effective 04/28/16
DOCUMENTATION REQUIREMENTS:
Revised: Standard documentation language for orders, ACA order requirements, added New order requirements, and Correct coding instructions; revised Proof of delivery instructions – Effective 04/28/16

**Policy Article**
**Revision Effective Date: 07/01/2016**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised Standard Language to add Statutory Prescription (Order) Requirements, revised Face to Face and ACA requirements – Effective 04/28/2016

**High Frequency Chest Wall Oscillation Devices**
**LCD**
**Revision Effective Date: 07/01/2016**

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation language – ACA order requirements – Effective 04/28/16
DOCUMENTATION REQUIREMENTS:
Revised: Standard documentation language for orders, ACA requirements, and Proof of delivery instructions; added New order requirements, and Correct coding instructions – Effective 04/28/16

## LCD AND POLICY ARTICLES

**Policy Article**
**Revision Effective Date: 10/01/2015:**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised Standard Language to add Statutory prescription (order) requirements, revised Face to Face and ACA requirements – Effective 04/28/2016

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 LCDs and/or Policy Articles.

### LCD and Policy Article Revisions Summary for August 25, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for August 25, 2016" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for August 25, 2016 webpage.

## NEBULIZERS

### Nebulizers (HCPCS J7605, J7626) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code(s):

- **J7605:** Arformoterol, Inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 15 micrograms
- **J7626:** Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 0.5 mg

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Nebulizers (HCPCS J7605, J7626) Notification of Service Specific Prepayment Targeted Review.

## Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1970, L4360, L4361) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code(s):

- **L1970:** Ankle Foot Orthosis, Plastic with Ankle Joint, Custom-Fabricated
- **L4360:** Walking Boot, Pneumatic and/or Vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
- **L4361:** Walking Boot, Pneumatic and/or Vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1970, L4360, L4361) Notification of Service Specific Prepayment Targeted Review.

## Knee Orthoses (HCPCS L1832, L1833) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code(s):

- **L1832:** Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
- **L1833:** Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Knee Orthoses (HCPCS L1832, L1833) Notification of Service Specific Prepayment Targeted Review.

## Spinal Orthoses (HCPCS L0648, L0650) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS codes:

- **L0648:** Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
- **L0650:** Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Spinal Orthoses: TLSO and LSO (HCPCS L0648, L0650) Notification of Service Specific Prepayment Targeted Review.

# OVERPAYMENTS AND REFUNDS

## Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

**Source:** Transmittal 50, Change Request 3274, dated July 30, 2004

# OXYGEN

## Oxygen (HCPCS E0431, E1390) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code(s):

- **E0431:** Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask and tubing
- **E1390:** Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Oxygen (HCPCS E0431, E1390) Notification of Service Specific Prepayment Targeted Review.

# Documentation for DMEPOS Claims for Replacement of Essential Accessories for Beneficiary-Owned CPAP Devices and RADs

**MLN Matters® Number: MM9741**
**Related Change Request (CR) #: CR 9741**
**Related CR Release Date: August 19, 2016**
**Effective Date: July 1, 2016**
**Related CR Transmittal #: R672PI**
**Implementation: November 2, 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) for replacement of essential accessories for beneficiary-owned Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) paid under the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

## What You Need to Know

Change Request (CR) 9741 provides guidance to the MACs for handling claims for replacement of essential accessories for beneficiary-owned CPAP devices and RADs purchased by Medicare. When making a payment determination, MACs will review the necessity of replacing a CPAP or RAD accessory when the beneficiary-owned base CPAP or RAD continues to meet the medical need requirements.

## Background

The Centers for Medicare & Medicaid Services (CMS) is alerting providers that due to the changing environment occurring in the DMEPOS industry, Medicare beneficiaries are having difficulty locating suppliers to replace accessories for beneficiary-owned equipment when the original supplier's documentation for the base CPAP or RAD is not available.

Your MAC will require documentation when conducting medical review of DMEPOS claims for replacement of essential accessories for beneficiary-owned CPAP or RADs.

CMS provides the following guidance to the MACs by identifying the documentation required when conducting medical review of DMEPOS claims for replacement of essential accessories for beneficiary-owned CPAP or RADs.

For purposes of reviews on replacement of accessories claims, if Medicare paid for the base CPAP or RAD initially (that is, for 13 months of continuous use), the medical necessity for the beneficiary-owned base CPAP or RAD is assumed to have been established. Even though a face-to-face encounter is required for the initial provision of the CPAP device, it is not needed for replacement of essential accessories for a patient-owned CPAP device purchased by Medicare.

Therefore, to make a payment determination MACs will only review:

- The base DME item continued medical need requirements, including documentation from the physician or treating practitioner that indicates the CPAP or RAD that requires replacement accessories continues to be medically necessary. For this purpose, documentation is considered timely when it is on record in the preceding 12 months; and
- The medical necessity of the replacement of specific accessories or furnishing of new accessories and whether they are essential for the effective use of the base DME.

Be aware that your MAC will ensure that the supplier's documentation records support the need to replace the accessory to maintain the equipment's functionality and meet the beneficiary's medical need. In the event that certain accessories are furnished for the first time, such as a heated humidifier or heated tubing, contractors will ensure that the accessories are medically necessary.

## PAP DEVICES

This guidance for replacement of essential accessories is to be applied only to CPAP and RADs owned by Medicare beneficiaries when Medicare initially paid for the base DME item. This guidance does not apply to CPAP or RADs when Medicare did not originally provide payment for the base item. In cases where Medicare did not originally pay for the DME item, all coverage, coding and documentation requirements in effect for the Date of Service (DOS) on the claim under review must be met.

### Additional Information

The official instruction, CR9741 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R672PI.pdf.

## Positive Airway Pressure (PAP) (HCPCS E0601) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for the following HCPCS code:

- **E0601:** Continuous positive airway pressure (CPAP) device

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Positive Airway Pressure (PAP) (HCPCS E0601) Notification of Service Specific Prepayment Targeted Review.

## PATIENT LIFTS

## Patient Lifts (HCPCS E0630) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for the following HCPCS code:

- **E0630:** Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Patient Lifts (HCPCS E0630) Notification of Service Specific Prepayment Targeted Review.

# Correct Coding – WHILL Powered Personal Mobility Devices

## DME MAC Joint Publication

**Revised July 21, 2016**
**Posted May 14, 2015**

This is a revision to the article, "Correct Coding – WHILL Model A Powered Personal Mobility Device" published in May, 2015. The article is retitled as above and revised to include the WHILL Model M.

WHILL, Inc., (San Carlos, CA), is the manufacturer of WHILL powered personal mobility devices. They currently have two products, Model A and Model M.

### WHILL Model A

The WHILL Model A has not been cleared by the FDA and is not considered to be a medical device. Consequently, this item is non-covered (no Medicare benefit). For Medicare billing purposes, claims for the WHILL Model A must be submitted using HCPCS code:

- **A9270 –** NONCOVERED ITEM OR SERVICE

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

### WHILL Model M

The WHILL Model M received a 510(k) FDA clearance for marketing as a Class II Powered Wheelchair on February 12, 2016. A HCPCS code request for this product has not been submitted to the Pricing, Data Analysis and Coding (PDAC) Contractor. For Medicare billing purposes, claims for this device must be submitted using HCPCS code:

- **K0899 –** POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA

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

### General Information

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

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

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

# ATP RESNA Certification Requirement Reminder

Suppliers should include verification of Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification for the Assistive Technology Professional (ATP) involved in the selection of the wheelchair with documentation submitted in response to additional documentation requests (ADRs) for complex medical review. This is in order to ensure that the following stated requirements are fulfilled.

The following wheelchairs and accessories require that the following items are provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient:

- **K0005:** Manual ultra-lightweight wheelchair
- **E1161:** Tilt-in-space manual wheelchair
- **K0835–K0840:** Group 2 Single Power Option PWC

- **K0841–K0843:** Group 2 Multiple Power Option PWC
- **K0848–K0855:** Group 3 PWC with no power options
- **E0986:** Push-rim activated power assist device
- **E2227:** A gear reduction drive wheel
- **E0988:** Lever activated wheel drive
- **E1002–E1010:** Power tilt and/or recline seating systems

Additional Resources for further clarification of this requirement:

- FAQ – Power Mobility Devices – Supplier ATP Involvement
- Local Coverage Determination (LCD) for Manual Wheelchair Bases LCD L11454 and related Policy Article (PA) A25378
- LCD for Power Mobility Devices L23598 and related PA A41127
- LCD for Wheelchair Options/Accessories L11462 and related PA A19846

## Attestation Statements Must Accompany ADMC, PAR and PMD Claims for Medical Review

Noridian Medicare DME would like to take the opportunity to remind suppliers that an attestation statement is required for a licensed/certified medical professional (LCMP) evaluation to be considered as part of the face-to-face examination for a power mobility device. To fulfill this requirement the attestation must be signed and dated and submitted with all Power Mobility Device (PMD) claims, Prior Authorization Requests (PAR), and Advanced Determination of Medical Coverage's (ADMC) submissions.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier. (**Note:** Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the physician.)

Additional resources include the National Coverage Determination (NCD) 280.3, Local Coverage Determinations (LCDs) L23598, L11462, L15670 and Policy Articles (PA) A41127, A19846, A17265 and CMS Publication 100-8, Program Integrity Manual Chapter 3.

## Face-to-Face Examination Date on 7-Element Order for Power Mobility Device Scenarios

**Question:** What date should be reported on the 7-element order for the face-to-face (F2F) examination for power mobility devices (PMDs)?

**Response:** The required PMD F2F examination has two components. These components are:

1. Decision component – An in-person visit between the beneficiary and the ordering physician to document the decision to order a PMD; and,
2. Medical evaluation component – A medical examination to document the beneficiary's mobility and functional condition.

Both components are required and must be documented in the prescribing physician's records.

Several possible scenarios can affect the determination of the correct F2F examination date.

## F2F Scenarios

- The ordering physician completes the entire F2F examination (both #1 & #2 above) during the initial, inperson encounter with the beneficiary. If this is the case, the date of the F2F examination is the date of that in-person encounter.
- The ordering physician has an initial in-person encounter with the beneficiary (#1 above) but does not complete the medical evaluation component (#2 above) of the F2F examination at this initial visit. At a subsequent visit with the ordering physician, the medical evaluation component is completed. In this situation, the date of the F2F examination is the date of the subsequent in-person encounter when the medical evaluation is completed.
- The ordering physician completes the decision component (#1 above) of the F2F examination at the initial in-person encounter with the beneficiary. The beneficiary is referred to another licensed clinical medical professional (LCMP) such as an Occupational Therapist (OT) or Physical Therapist (PT), who has experience and training in mobility evaluations, to perform all or a portion of the medical evaluation component (#2 above) of the F2F examination. The physician must indicate concurrence or any disagreement with the information in the written evaluation, sign and date the document. The F2F date listed on the 7-element order is the date the physician signed, dated and indicated concurrence or disagreement with the LCMP mobility evaluation.
- The ordering physician refers the beneficiary to an LCMP prior to the in-person encounter (#1 above) with the beneficiary. Once the physician has received and reviewed (stated concurrence, signed, and dated) the written report of the LCMP medical examination (#2 above), the physician must see the beneficiary and complete the decision component (#1 above). In this scenario, the date of the F2F examination reported on the 7-element order would be the date of the in-person encounter between the physician and beneficiary.
- The F2F examination is performed and completed during an inpatient hospital or nursing home stay, the date of the F2F examination reported on the 7-element order is either: 1) the date that both components 1 and 2 above are completed; or, 2) the date of discharge.
- The F2F examination has been completed, but the physician later identifies that there is information not properly documented in the medical record about the beneficiary which is necessary to support coverage criteria for a PMD. If the physician provides an amendment, correction or addenda to the F2F examination with information that arose from the previously performed F2F evaluation (both #1 & #2 above), the F2F examination date does not change on the 7-element order. The amendment, correction or addenda to the F2F evaluation should appear in the beneficiary's medical record.
- The F2F examination has been completed, but the physician later identifies that there is information that was not addressed during the F2F examination (both #1 & #2 above) which is necessary to support coverage criteria for a PMD. The physician must provide this new information in the medical record but since this was not a part of the original F2F, this does require a new in-person visit for the patient with the physician. This new F2F visit date becomes the F2F date on the 7-element order.

If the date of the F2F examination is entered incorrectly or if any other information on the 7-element order must be corrected, it is recommended the supplier request that the physician who completed the original 7-element order complete a new 7-element order. However, if a new 7-element order cannot be obtained, a corrected 7-element order is acceptable only when properly corrected/amended by the physician who originally signed it.

Any deletion and/or addition made to the 7-element order must be entered only by the physician who created the original 7-element-order, who must legibly sign and date the change.

In addition, a corrected 7-element-order is acceptable only when the corrections/amendments are made prior to the completion of any detailed product description and prior to the date of service of the claim.

Suppliers are encouraged to review the Program Integrity Manual available on the Centers for Medicare & Medicaid Services website for additional information on amendments, corrections and delayed entries in medical documentation. This can be found in publication 100-08, chapter 3, section 3.3.2.5.

Additional information on how to change a 7-element order can be found in an article titled, "Changing a 7-Element-Order for a Power Mobility Device", available on the Noridian website. Suppliers can obtain additional information regarding medical necessity and documentation requirements for Power Mobility Devices in the Power Mobility Devices Local Coverage Determination (L23598) and Policy Article (A41127) which are also available on the Noridian website.

## Manual Wheelchairs (HCPCS K0001, K0003) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS code(s):

- **K0001:** Standard wheelchair
- **K0003:** Lightweight wheelchair

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Manual Wheelchairs (HCPCS K0001, K0003) Notification of Service Specific Prepayment Targeted Review.

## Group 3 Complex Rehabilitative Power Wheelchair Accessories Reopening Guidance

Beginning July 5, 2016, suppliers may request a Reopening for certain wheelchair accessories furnished in connection with Group 3 complex rehabilitative power wheelchair claims for dates of service on/after January 1, 2016 which were previously processed at the blended amounts. They will be adjusted to the fee schedule amount when a request to add the KU modifier is received by the DME MAC. Read the complete article.

# PRESSURE REDUCING SUPPORT SURFACES

## Pressure Reducing Support Surfaces – Group 2 (HCPCS E0277) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for the following HCPCS code:

- **E0277:** Powered pressure-reducing air mattress

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Pressure Reducing Support Surfaces – Group 2 (HCPCS E0277) Notification of Service Specific Prepayment Targeted Review.

# DMEPOS Fee Schedule – October 2016 Quarterly Update

**MLN Matters® Number: MM9756**
**Related Change Request (CR) #: CR 9756**
**Related CR Release Date: August 26, 2016**
**Effective Date: October 1, 2016**
**Related CR Transmittal #: R3598CP**
**Implementation: October 3, 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) 9756 advises providers of fee schedule amounts for codes in effect on October 1, 2016. Make sure your billing staffs are aware of these updates.

## Key Points

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60.

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 fee schedule amounts. 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.

October quarterly updates are only required for the DMEPOS Rural ZIP Code file containing Quarter 4, 2016 Rural ZIP Code changes. MACs will process claims for DMEPOS items using the Rural ZIP code file for dates of service on or after October 1, 2016.

The October 2016 DMEPOS Rural ZIP Code Public Use File (PUF), containing the rural ZIP codes effective for Quarter 4, 2016, will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above PUF.

## Additional Information

The official instruction, CR 9756, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3598CP.pdf.

Chapter 23 of the "Medicare Claims Processing Manual" is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.

# REMITTANCE ADVICE

## Electronic Remittance Advice Benefits – 835 Transaction

The Electronic Remittance Advice (ERA) is the electronic version of the Standard Paper Remit (SPR), which serves as a notice of payment and adjustments sent to providers, billers and suppliers and explains the reimbursement decisions of the payer.

A facility may be receiving the 835 Remittance Advice but suppliers may need to network internally to obtain a copy of the remittance advice for departmental purposes. If a facility is currently not set up to receive the 835 Remittance Advice, view several transaction benefits on the Electronic Remittance Advice webpage.

Electronic Data Interchange Support Services (EDISS) provides a list of Medicare-approved connectivity vendors for direct submitters on the EDI website at http://edissweb.com/cgp/software/.

# THERAPEUTIC SHOES

## Therapeutic Shoes for Persons with Diabetes (HCPCS A5500) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for the following HCPCS code:

- **A5500:** For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth0inlay show manufactured to accommodate multi-density insert(s), per shoe

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Therapeutic Shoes for Persons with Diabetes (HCPCS A5500) Notification of Service Specific Prepayment Targeted Review.

# UPDATES

## Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM9680
Related Change Request (CR) #: CR 9680
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3599CP
Implementation Date: January 3, 2017

### Provider Types Affected

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

### What You Need to Know

Change Request (CR) 9680 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgement transactions.

### Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276.277 transactions to report claim status.

The National Code Maintenance Committee (NCMC) meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC allows the industry 6 months for implementation of newly added or changed codes. Codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2016 committee meeting shall be posted on these sites on or about November 1, 2016. MACs will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation of CR9680.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date CR9680 is implemented.

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

### Additional Information

The official instruction, CR9680, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3599CP.pdf.

## RARC, CARC, MREP and PC Print Update

**MLN Matters® Number: MM9695**
**Related Change Request (CR) #: CR 9695**
**Related CR Release Date: July 15, 2016**
**Effective Date: October 1, 2016**
**Related CR Transmittal #: R3562CP**
**Implementation Date: October 3, 2016**

### Provider Types Affected

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

### Provider Action Needed

Change Request (CR) 9695 informs MACs about the changes that update the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists, and CR9695 calls for an update to the Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes. If you use the MREP and/or PC Print software, be sure to obtain the latest version that is released on or before October 3, 2016.

### Background

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

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

CR9695 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's Standard System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR9695, MACs must implement on the date specified on the WPC website at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated 3 times a year and may not match the CMS release schedule.

### Additional Information

The official instruction, CR9695, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3562CP.pdf.

## Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule – Update from CAQH CORE

**MLN Matters® Number: MM9696**
**Related Change Request (CR) #: CR 9696**
**Related CR Release Date: July 1, 2016**
**Effective Date: October1, 2016**
**Related CR Transmittal #: R3558CP**
**Implementation Date: October 3, 2016**

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 9696 which instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2016. Make sure that your billing staff is aware of these changes. In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

### Background

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

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C–Administrative Simplification–to Title XI of the Social Security Act, requiring the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CAQH CORE lists the June 2016 version on the Code Combination List website. This update includes CARC and RARC updates as posted at the Washington Publication Company (WPC) website on or about March 1, 2016. This will also include updates based on Market Based Review (MBR) that the CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

### Additional Information

The official instruction, CR9696, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3558CP.pdf on the CMS website.

The WPC website is at http://www.wpc-edi.com/reference/.

The CAQH CORE Code Combination List is available at http://www.caqh.org/CORECodeCombinations.php.

## Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule – Update from CAQH CORE

**MLN Matters® Number: MM9766**
**Related Change Request (CR) #: CR 9766**
**Related CR Release Date: August 26, 2016**
**Effective Date: January 1, 2017**
**Related CR Transmittal #: R3600CP**
**Implementation Date: January 3, 2017**

### Provider Types Affected

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

### Provider Action Needed

Change Request (CR) 9766 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 – Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

### Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C–Administrative Simplification–to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR9766 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 – Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2016. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about July 1, 2016. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

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

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

### Additional Information

The official instruction, CR9766, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3600CP.pdf.



## Urological Supplies (HCPCS A4351, A4352, A4353) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction A, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for each of the following HCPCS codes:

- **A4351:** Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each
- **A4352:** Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each
- **A4353:** Intermittent urinary catheter, with insertion supplies

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Urological Supplies (HCPCS A4351, A4352, A4353) Notification of Service Specific Prepayment Targeted Review.

noridian Healthcare Solutions
DME Happenings
900 42nd St. S.
Fargo, ND 58103

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES