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

September 2013
Number 29

How is the Service Provided by NHIC, Corp.?

Have you registered to participate in the Medicare Administrative Contractor (MAC) Satisfaction Indicator (MSI) yet? The MSI is a questionnaire that asks about your satisfaction with specific services your MAC provides you, such as claims processing, Medicare enrollment, educational opportunities, and responsiveness to inquiries.

We are seeking to collect accurate contact information by having providers complete the MSI Participant Registration form. The form itself is not a survey. It is a method for gathering pertinent contact information such as name, email address, state, etc. It should take less than 1 minute to complete. For each MSI administration, CMS will randomly select its MSI sample from a list of providers who register to become participants.

So, come on! If you are a Medicare FFS provider, or work on behalf of a Medicare FFS provider (such as a billing agency), and are interested in participating, take a moment to register your contact information by completing the application. Don't miss this opportunity.

For more information about the MSI visit the CMS MSI web site at:
http://www.cms.gov/Medicare/Medicare-Contracting/MSI/

Upcoming DME MAC Jurisdiction A In-Person Events

2013 DME MAC Jurisdiction A In-Person Seminars - *Building Your Medicare Knowledge to New Heights*
The Provider Outreach & Education (POE) Team is excited to be hosting six educational events offering a dynamic range of topics. The theme for these sessions is "*Building Your Medicare Knowledge to New Heights*". Attendees will learn everything from the basics, to detailed documentation requirements, to recent Medicare changes during this one day learning experience.

2013 DME MAC Jurisdiction A Special Events - *Be Prepared - Audits and Documentation Compliance*
The Provider Outreach & Education Team will be partnering with the DME MAC A Medical Review Manager to offer special educational sessions on Medicare Audits. The courses will highlight some common audit pitfalls and how to prevent and correct these issues. The morning session will be specific to audits affecting Orthotic & Prosthetic (O&P) suppliers and the afternoon session will focus on audits affecting the Durable Medical Equipment (DME) industry.

For more information about the DME MAC A Events visit our Events & Seminars web page at:
http://www.medicarenhic.com/dme/dmerc_seminars.shtml

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

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Legend

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

Additional States Requiring Payment Edits for DMEPOS Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics. Update to CR 3959 (MM8390) (O&P)

MLN Matters® Number: MM8390
Related CR Release Date: August 2, 2013
Related CR Transmittal #: R2755CP
Related Change Request (CR) #: CR8390
Effective Date: October 5, 2013
Implementation Date: October 5, 2013

Provider Types Affected

This MLN Matters® article is intended for suppliers in Alabama, Arkansas, Florida, Georgia, Illinois, Kentucky, Mississippi, New Jersey, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, and Washington , , who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Prosthetics and Orthotics (P&O) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8390 which instructs DME MACs to revise programming edits so that Arkansas, Georgia, Kentucky, Mississippi, and Tennessee are added to the logic, in accordance with CR3959 (Transmittal 656; August 19, 2005). CR3959 instructed DME MACs to implement claims processing edits to ensure compliance with CMS regulations which require Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers wishing to bill Medicare to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements. At the time CR3959 was issued and DME MACs implemented the edit, there were nine (9) states (including Alabama, Florida, Illinois, New Jersey, Ohio, Oklahoma, Rhode Island, Texas, and Washington) which required the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. Since that time, five (5) additional states have instituted requirements for the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. CR8390 instructs DME MACs to revise programming edits so that the five additional states including Arkansas, Georgia, Kentucky, Mississippi, and Tennessee are added to the logic, in accordance with CR3959.

See the Background and Additional Information Sections of this article for further details, and make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 3959 (Transmittal 656) on August 19, 2005, which instructed DME MACs to implement claims processing edits to ensure compliance with CMS regulations found at 42 CFR 424.57(c)(1). Such regulations require DMEPOS suppliers wishing to bill Medicare to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements.

You can find the MLN Matters® article (MM3959) corresponding to CR3959 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3959.pdf** on the CMS website. You can also review 42 CFR § 424.57(c)(1) at **http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=5f8d8d2cda131ddbf2c2e24b532cce14&rgn=div8&view=text&node=42:3.0.1.1.11.4.5.8&idno=42** on the Internet.

CR8390 instructs DME MACs to revise programming edits so that Arkansas, Georgia, Kentucky, Mississippi, and Tennessee are added to the logic, in accordance with CR3959. You can review the list of Healthcare Common Procedure Coding System (HCPCS) codes for customized orthotics and prosthetics affected by edit. That is attached to CR3959 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r656cp.pdf** on the CMS website.

Additional Information

The official instruction, CR8390, issued to your DME MACs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2755CP.pdf** on the CMS website. If you

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

Coding Requirements for Laboratory Specimen Collection Update (MM8339) (SPE)

MLN Matters® Number: MM8339 Revised
Related CR Release Date: June 20, 2013
Related CR Transmittal #: R2730CP

Related Change Request (CR) #: CR 8339
Effective Date: July 16, 2013
Implementation Date: July 16, 2013

Note: *This article was revised on June 24, 2013, to reflect the revised CR8339 issued on June 20. The narrative for CPT 36415 has been revised. The CR release date, transmittal number and the Web address for accessing the CR were also revised. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8339, which advises you that the current Centers for Medicare & Medicaid Services (CMS) instructions found at the "*Medicare Claims Processing Manual*," Chapter 16, Section 60.1.4, are being updated due to questions received from the laboratory industry. The CR corrects the codes listed in the manual for claims for laboratory specimen collection services. There is no change in policy or in claims processing. CMS is just updating the manual.

Background

Current CMS instructions have a terminated code listed in the manual for the routine venipuncture for collection of specimens. CMS is releasing this update to these manual instructions to list the active code and address questions received from the laboratory industry. Since the fee schedules and systems were updated when the coding change occurred, there is no need to include any system or fee schedule updates.

"*The Medicare Claims Processing Manual*," Chapter 16, Section 60.1.4 - Coding Requirements for Specimen Collection, is revised to add the following:

"The following Health Care Common Procedure Coding System (HCPCS) codes and terminology must be used:

- **36415 - Collection of venous blood by venipuncture.**
- P96l5 - Catheterization for collection of specimen(s)."

The allowed amount for specimen collection in each of the above circumstances is included in the laboratory fee schedule distributed annually by CMS.

Additional Information

The official instruction, CR8339 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2730CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Detailed Written Orders and Face-to-Face Encounters (MM8304) (GEN)

MLN Matters® Number: MM8304 Revised
Related CR Release Date: May 31, 2013
Related CR Transmittal #: R468PI

Related Change Request (CR) #: CR 8304
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: *This article was revised on June 28, 2013, to provide clarifying language on page 2 and to provide a Web address for a relevant portion of the "Program Integrity Manual" on page 2. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for physicians, Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for certain Durable Medical Equipment (DME) items and services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8304, which instructs DME MACs to implement requirements, which are effective July 1, 2013, for detailed written orders for face-to-face encounters conducted by the physician, PA, NP or CNS for certain DME items as defined in 42 CFR 410.38(g). (That section is available at **http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-38.pdf** on the Internet.)

Due to concerns that some providers and suppliers may need additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the *Affordable Care Act* for certain items of DME, the Centers for Medicare & Medicaid Services (CMS) will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on October 1, 2013.

Section 6407 of the *Affordable Care Act* established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

Although many durable medical equipment suppliers and physicians are aware of and are able to comply with this policy, CMS is concerned that some may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the next several months, suppliers and physicians who order certain DME items will continue to collaborate and establish internal processes to ensure compliance with the face-to-face requirement. CMS expects durable medical equipment suppliers to have fully established such internal processes and have appropriate documentation of required encounters by October 1, 2013.

CMS will continue to address industry questions concerning the new requirements and will update information on at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/index.html** on the CMS website. CMS and its contractors will also use other communication channels to ensure that the provider community is properly informed of this announcement.

Background

As a condition for payment, Section 6407 of the *Affordable Care Act* requires a physician to document that the physician, PA, NP or CNS has had a face-to-face encounter examination with a beneficiary in the six (6) months prior to the written order for certain items of DME (the complete list of items is found in Appendix A at the end of this article). This section does not apply to Power Mobility Devices (PMDs) as these items are covered under a separate requirement.

This includes encounters conducted via the Centers for Medicare & Medicaid Services (CMS)-approved use of telehealth (as described in Chapter 15 of the "*Medicare Benefit Policy Manual*" and Chapter 12 of the "*Medicare Claims Processing Manual*"). Those manuals are available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html** on the CMS website.

Note that the date of the written order must not be prior to the date of the face-to-face encounter.

The face-to-face encounter conducted by the physician, PA, NP, or CNS must document that the beneficiary was evaluated and/or treated for a condition that supports the item(s) of DME ordered.

In the case of a DME ordered by a PA, NP, or CNS, a physician (MD or DO) must document the occurrence of a face-to-face encounter by signing/co-signing and dating the pertinent portion of the medical record. CMS will accept a single confirming signature, including the date, as sufficient if there are several pertinent portions of the medical record.

The written order for the DME must follow the guidance in the CMS "*Program Integrity Manual*," Chapter 5, Section 5.2.3 (available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html**) and include, at a minimum;

1. the beneficiary's name,
2. the item of DME ordered,
3. the prescribing practitioner's National Provider Identifier (NPI),
4. the signature of the ordering practitioner and
5. the date of the order.

Failure to meet any of the above requirements will result in denial of the claim.

Physicians will be provided an additional payment, using code G0454, for signing/co-signing the face-to-face encounter of the PA/NP/CNS. The physician should not bill the G code when he/she conducts the face-to-face encounter. Note that the G code may only be paid to the physician one time per beneficiary per encounter, regardless of the number of covered items documented in the face-to-face encounter.

CR8304 implements these changes in Chapter 5 of the "*Program Integrity Manual*" to support 42 Code of Federal Regulations (CFR) 410.38(g) and the revised portion of that manual is attached to CR8304.

Additional Information

The official instruction, CR8304, issued to your DME MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R468PI.pdf** on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Appendix A

The DME list of Specified Covered Items are as follows, the original list was at 77 FR 44798:

HCPCS Code	Description
E0185	Gel or gel-like pressure mattress pad
E0188	Synthetic sheepskin pad
E0189	Lamb's wool sheepskin pad
E0194	Air fluidized bed
E0197	Air pressure pad for mattress standard length and width
E0198	Water pressure pad for mattress standard length and width
E0199	Dry pressure pad for mattress standard length and width
E0250	Hospital bed fixed height with any type of side rails, mattress
E0251	Hospital bed fixed height with any type side rails without mattress
E0255	Hospital bed variable height with any type side rails with mattress
E0256	Hospital bed variable height with any type side rails without mattress
E0260	Hospital bed semi-electric (Head and foot adjustment) with any type side rails with mattress
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress
E0265	Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress
E0266	Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress
E0290	Hospital bed fixed height without rails with mattress
E0291	Hospital bed fixed height without rail without mattress
E0292	Hospital bed variable height without rail without mattress
E0293	Hospital bed variable height without rail with mattress
E0294	Hospital bed semi-electric (head and foot adjustment) without rail with mattress
E0295	Hospital bed semi-electric (head and foot adjustment) without rail without mattress
E0296	Hospital bed total electric (head, foot and height adjustments) without rail with mattress
E0297	Hospital bed total electric (head, foot and height adjustments) without rail without mattress

HCPCS Code	Description
E0300	Pediatric crib, hospital grade, fully enclosed
E0301	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, without mattress
E0302	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress
E0303	Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, with mattress
E0304	Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, with mattress
E0424	Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous (1 months supply)
E0442	Oxygen contents, liquid (1 months supply)
E0443	Portable Oxygen contents, gas (1 months supply)
E0444	Portable oxygen contents, liquid (1 months supply)
E0450	Volume control ventilator without pressure support used with invasive interface
E0457	Chest shell
E0459	Chest wrap
E0460	Negative pressure ventilator portable or stationary
E0461	Volume control ventilator without pressure support node for a noninvasive interface
E0462	Rocking bed with or without side rail
E0463	Pressure support ventilator with volume control mode used for invasive surfaces
E0464	Pressure support vent with volume control mode used for noninvasive surfaces
E0470	Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface
E0471	Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface
E0480	Percussor electric/pneumatic home model
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High Frequency chest wall oscillation air pulse generator system
E0484	Oscillatory positive expiratory device, non-electric
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic, large volume
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter
E0585	Nebulizer with compressor & heater
E0601	Continuous airway pressure device
E0607	Home blood glucose monitor
E0627	Seat lift mechanism incorporated lift-chair
E0628	Separate Seat lift mechanism for patient owned furniture electric
E0629	Separate seat lift mechanism for patient owned furniture non-electric
E0636	Multi positional patient support system, with integrated lift, patient accessible controls
E0650	Pneumatic compressor non-segmental home model
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure
E0655	Non- segmental pneumatic appliance for use with pneumatic compressor on half arm
E0656	Non- segmental pneumatic appliance for use with pneumatic compressor on trunk
E0657	Non- segmental pneumatic appliance for use with pneumatic compressor chest
E0660	Non- segmental pneumatic appliance for use with pneumatic compressor on full leg
E0665	Non- segmental pneumatic appliance for use with pneumatic compressor on full arm
E0666	Non- segmental pneumatic appliance for use with pneumatic compressor on half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full-leg

HCPCS Code	Description
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg
E0671	Segmental gradient pressure pneumatic appliance full leg
E0672	Segmental gradient pressure pneumatic appliance full arm
E0673	Segmental gradient pressure pneumatic appliance half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0692	Ultraviolet light therapy system panel treatment 4 foot panel
E0693	Ultraviolet light therapy system panel treatment 6 foot panel
E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of TENS or NMES
E0740	Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator electric shock unit
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spine application.
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal application
E0749	Osteogenesis stimulator, electrical, surgically implanted
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive
E0762	Transcutaneous electrical joint stimulation system including all accessories
E0764	Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls
E0765	FDA approved nerve stimulator for treatment of nausea & vomiting
E0782	Infusion pumps, implantable, Non-programmable
E0783	Infusion pump, implantable, Programmable
E0784	External ambulatory infusion pump
E0786	Implantable programmable infusion pump, replacement
E0840	Tract frame attach to headboard, cervical traction
E0849	Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, cervical collar with inflatable air bladder
E0958	Manual wheelchair accessory, one-arm drive attachment
E0959	Manual wheelchair accessory-adapter for Amputee
E0960	Manual wheelchair accessory, shoulder harness/strap
E0961	Manual wheelchair accessory wheel lock brake extension handle
E0966	Manual wheelchair accessory, headrest extension
E0967	Manual wheelchair accessory, hand rim with projections
E0968	Commode seat, wheelchair
E0969	Narrowing device wheelchair
E0971	Manual wheelchair accessory anti-tipping device
E0973	Manual wheelchair accessory, adjustable height, detachable armrest
E0974	Manual wheelchair accessory anti-rollback device
E0978	Manual wheelchair accessory positioning belt/safety belt/ pelvic strap
E0980	Manual wheelchair accessory safety vest
E0981	Manual wheelchair accessory Seat upholstery, replacement only
E0982	Manual wheelchair accessory, back upholstery, replacement only
E0983	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control
E0984	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control
E0985	Wheelchair accessory, seat lift mechanism
E0986	Manual wheelchair accessory, push activated power assist
E0990	Manual wheelchair accessory, elevating leg rest
E0992	Manual wheelchair accessory, elevating leg rest solid seat insert
E0994	Arm rest
E1014	Reclining back, addition to pediatric size wheelchair

HCPCS Code	Description
E1015	Shock absorber for manual wheelchair
E1020	Residual limb support system for wheelchair
E1028	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029	Wheelchair accessory, ventilator tray
E1030	Wheelchair accessory, ventilator tray, gimbaled
E1031	Rollabout chair, any and all types with castors 5” or greater
E1035	Multi-positional patient transfer system with integrated seat operated by care giver
E1036	Patient transfer system
E1037	Transport chair, pediatric size
E1038	Transport chair, adult size up to 300lb
E1039	Transport chair, adult size heavy duty >300lb
E1161	Manual Adult size wheelchair includes tilt in space
E1227	Special height arm for wheelchair
E1228	Special back height for wheelchair
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system
E1233	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system
E1296	Special sized wheelchair seat height
E1297	Special sized wheelchair seat depth by upholstery
E1298	Special sized wheelchair seat depth and/or width by construction
E1310	Whirlpool non-portable
E2502	Speech Generating Devices prerecord messages between 8 and 20 Minutes
E2506	Speech Generating Devices prerecord messages over 40 minutes
E2508	Speech Generating Devices message through spelling, manual type
E2510	Speech Generating Devices synthesized with multiple message methods
E2227	Rigid pediatric wheelchair adjustable
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength ltwt wheelchair
K0005	Ultra Lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0009	Other manual wheelchair/base
K0606	AED garment with electronic analysis
K0730	Controlled dose inhalation drug delivery system

Enrollment Denials When Overpayment Exists (MM8039) (GEN)

MLN Matters® Number: MM8039
Related CR Release Date: May 31, 2013
Related CR Transmittal #: R469PI

Related Change Request (CR) #: CR 8039
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Note: *This article has been rescinded due to the related CR being rescinded. The CR and article will be replaced at a later date.*

Additional Information

The official instruction, CR8039, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R469PI.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Further Instruction to Use Non-Alert Remittance Advice Remark Codes (RARCs) (MM8391) (GEN)

MLN Matters® Number: MM8391 Revised
Related CR Release Date: August 16, 2013
Related CR Transmittal #: R1285OTN

Related Change Request (CR) #: CR 8391
Effective Date: October 1, 2013
Implementation Date: October 7, 2013, except January 6, 2014 for DME MACs

Note: *This article was revised on August 22, 2013, to revise the title. All other information is the same.*

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 7910 was implemented by Medicare in April, 2013. CR7910 included a Business Requirement (BR 7910.2) instructing the Medicare Shared Systems (SSs) and contractors to stop sending Non-Alert Remittance Advice Remark Codes (RARCs) without associated Group Codes and/or Claim Adjustment Reason Codes (CARCs). It has been reported that this resulted in provider concern and increased provider inquiries. The Centers for Medicare & Medicaid Services (CMS) is working on developing a long term resolution but has decided to continue to send Non-Alert RARCs without any Group Code and/or CARC for now.

Additional Information

The official instruction, CR8391 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1285OTN.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Healthcare Provider Taxonomy Codes (HPTC) Update, October 2013 (MM8417) (GEN)

MLN Matters® Number: MM8417
Related CR Release Date: August 9, 2013
Related CR Transmittal #: R2762

Related Change Request (CR) #: CR 8417
Effective Date: October 1, 2013
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, A/B Medicare Administrative Contractors (MACs), Regional Home Health Intermediaries

(RHHIs), Home Health & Hospice Medicare Administrative Contractors (HH&H MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services to Medicare beneficiaries.

What You Need To Know

Change Request (CR) 8417, from which this article is taken, instructs Medicare contractors to obtain the most recent Healthcare Provider Taxonomy Codes (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) requires that covered entities use the standards adopted under this law when electronically transmitting certain health care transactions. These standards contain implementation guides that dictate when and how data must be sent, and specify the code sets that must be used.

Both the current ASC X12 837 institutional and professional claims require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate that a HPTC be on every claim, nor for every provider to be identified by specialty there.

They state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code" and
- "If not required by this implementation guide, do not send."

In addition, please note that Medicare does not use HPTCs to adjudicate its claims, and would not expect to see these codes on a Medicare claim. However, it does currently validate any HPTC that a provider happens to supply against the NUCC HPTC code set.

As the HPTC code set maintainer, the NUCC updates the code set twice a year (effective April 1 and October 1), and CR8417 implements the NUCC HPTC code set that is effective on October 1, 2013. CR8417 instructs Medicare contractors and maintainers to obtain the October 2013 HPTC set, and to update the current HPTC Tables with this updated list. It further instructs the contractors and maintainers that: 1) Have the capability to implement the updated October 2013 HPTC set, to update the HPTC table so that claims received on and after October 1, 2013, can be validated against this updated set; or 2) Lack this capability, to implement the October 2013 HPTC update as soon as they can after October 1, 2013, but not beyond January 6, 2014.

The HPTC set is available for view or for download at **http://www.wpc-edi.com/reference/** on the Washington Publishing Company (WPC) website. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code: 1) New items are green; 2) Modified items are orange; and 3) Inactive items are red.

Additional Information

The official instruction, CR8417, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2762CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE (MM8365) (GEN)

MLN Matters® Number: MM8365
Related CR Release Date: August 16, 2013
Related CR Transmittal #: R1281OTN

Related Change Request (CR) #: CR 8365
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, A/B Medicare Administrative Contractors (MACs), Home Health & Hospice Medicare Administrative Contractors (HH&H), Durable

Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8365, from which this article is taken, instructs Medicare contractors and Shared System Maintainers (SSM) to use (effective January 1, 2014) the May 24, 2013 update to the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios, version 3.0.2.

Background

On August 7, 2012, the Department of Health and Human Services (HHS) announced adoption of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set. (Refer to **http://www.hhs.gov/news/press/2012pres/08/20120807a.html** on the Centers for Medicare & Medicaid Services (CMS) website). In CR8182, released on May 9, 2013, CMS instructed Medicare contractors to implement this rule set by January 6, 2014. (You can find the associated MLN Matters® Article, MM8182 "*Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8182.pdf** on the CMS website.)

The EFT & ERA Operating Rule Set includes the following rules:

1. Phase III CORE 380 EFT Enrollment Data Rule;
2. Phase III CORE 382 ERA Enrollment Data Rule;
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule: CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule
4. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
5. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

The *Health Insurance Portability and Accountability Act* (HIPAA) initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim or service has been adjudicated, and now the ERA/EFT Operating Rules under the *Affordable Care Act* are mandating consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios and specify the maximum set of the standard code combinations that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations of existing codes based on business policy change and/or Federal/State Mandate.

CR8365, from which this article is taken, focuses on rule 3 , and instructs Medicare contractors and Shared System Maintainers (SSM) to use (to be effective January 1, 2014, and to be implemented by January 6, 2014) the May 24, 2013 updated CORE Combination Lists in the document: "CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios," version 3.0.2 (which you will find as an attachment to CR8365).

The following are the CORE-defined Claim Adjustment/Denial Business Scenarios and Descriptions:

Scenario #1: Additional Information Required - Missing/Invalid/Incomplete Documentation
This scenario refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2: Additional Information Required - Missing/Invalid/Incomplete Data from Submitted Claim
Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3: Billed Service Not Covered by Health Plan
Refers to situations where the billed service is not covered by the health plan.

Scenario #4: Benefit for Billed Service Not Separately Payable
Refers to situations where the billed service or benefit is not separately payable by the health plan.

Medicare is implementing the code combinations per the ERA/EFT Operating Rules in 2 releases (July and October 2013) that relate to these 4 scenarios (per CR 8182), and is adding the updates to CORE CODE Combinations (per CR8365), effective January 1, 2014. Finally, the Medicare Remit Easy Print (MREP) and PC Print, will be updated if needed, by January 6, 2014.

Additional Information

The official instruction, CR8365 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1281OTN.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Infusion Pump Denied/Accessories & Drug Codes Should Be Denied (SE1327) (SPE)

MLN Matters® Number: SE1327
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: Not applicable (N/A)
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Article Special Edition (SE) is intended for suppliers of Durable Medical Equipment submitting claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for supplies and services to Medicare beneficiaries.

Provider Action Needed

Impact to You
Durable Medical Equipment suppliers who submit claims for infusion pumps need to know the billing requirements for infusion accessories and drugs.

What You Need to Know
When the infusion pump is denied, then the infusion accessories and infusion drugs are also denied.

What You Need to Do
Make sure that your billing staffs are aware of the billing requirements for infusion pumps, accessories and drugs.

Background

This article is based on the results of an automated review of claims for infusion pumps, accessories and drugs by the Recovery Auditors. When claims for infusion pumps are denied, claims for infusion accessories and for infusion drugs related to the denied pump should also be denied.

Here are two examples of incorrect billings:

- A 73 year-old male was denied an E0784 (Insulin external ambulatory infusion pump) on April 5, 2007.

  The same patient was then allowed 13 units of A4221 (supplies for maintenance of drug infusion catheter) and 30 units of K0552 (supplies for external drug infusion pump, syringe type cartridge) on April 5, 2007.

  No paid claims exist for the E0784 within the same rental month as the A4221 and K0552. Per Local Coverage Determination (LCD) 11570, supplies are covered if the related pump is covered. Therefore, the 13 units of A4221 and the 30 units of K0552 are overpaid for April 5, 2007.

- A 63 year-old female was denied an E0784 (Insulin external ambulatory infusion pump) on September 7, 2007.

  The same patient was then allowed 3 units of A4221 (supplies for maintenance of drug infusion catheter) on September 30, 2007.

  No paid claims exist for the E0784 within the same rental month as the A4221. Per LCD 11570, supplies are covered if the related pump is covered. Therefore, the 3 units of A4221 are overpaid for September 30, 2007.

How You Can Improve Your Billing

You are encouraged to review the following documents in the Local Coverage Determinations section of the Medicare Coverage Database:

- "External Infusion Pumps" addresses coverage indications, limitations, and medical necessity, coding and general information. Please find this document, updated 2/17/2013, posted by your DME MAC (L11555, L2745, L5044 or L11570), at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the Centers for Medicare & Medicaid Services (CMS) website.
- "External Infusion Pumps," policy article, effective 1/1/ 2013, discusses non-medical necessity coverage and payment rules and coding guidelines. This document, updated 3/15/2013, posted by your DME MAC (A20210, A47226, A19713, or A19834), is available at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the CMS website.
- The "*Medicare National Coverage Determinations Manual*," Chapter 1, Part 4, Coverage Determinations, Section 280.14, Infusion Pumps discusses coverage of external infusion pumps and is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf** on the CMS website.

Additional Information

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

July Quarterly Update for 2013 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM8325) (GEN)

MLN Matters® Number: MM8325 Revised
Related CR Release Date: May 17, 2013

Related CR Transmittal #: R2709CP

Related Change Request (CR) #: CR 8325
Effective Date: January 1, 2013 - for implementation of fee schedule amounts for codes in effect on January 1, 2013; July 1, 2013 for all other changes
Implementation Date: July 1, 2013

Note: *This article was revised on August 1, 2013, to add additional language to address questions raised about the implementation of the non-mail order fee schedule changes required by the American Taxpayer Relief Act.*

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (MACs), carriers, Regional Home Health Intermediaries (RHHIs) and Durable Medical Equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider Action Needed

This article is based on Change Request (CR) 8325 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

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

Key Points of CR8325

- CR 8325 updates fees for Healthcare Common Procedure Coding System (HCPCS) codes E2378, L5859, and L7902. These HCPCS codes were added to the HCPCS file effective January 1, 2013. Previously these items were paid on a local fee schedule. If claims for these codes with dates of service on or after January 1, 2013 have already been processed, they will be adjusted to reflect the new fees if you bring the claims to your contractor's attention.

- As part of this update fee schedule amounts are also established for HCPCS code K0009 (Other Manual Wheelchair/Base). Payment on a fee schedule basis is mandated for all DME by section 1834(a) of the *Social Security Act* (the Act), other than items that meet the definition of customized DME at 42 CFR section 414.224 of the regulations. Effective July 1, 2013, payment for claims for manual wheelchairs, that receive a HCPCS code verification of K0009 by the Pricing Data Analysis and Coding (PDAC) contractor, will be made on a capped rental basis with the fee schedule amounts established in accordance with section1834 (a)(8) of the Act using data for all manual wheelchair codes effective in 1986.

Diabetic Testing Supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the *American Taxpayer Relief Act* (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act. The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. This provision of the ATRA achieves competitive non-mail order prices for the same diabetic testing supplies furnished through the national mail order program without requiring local pharmacies to compete and be awarded contracts while still providing Medicare beneficiaries a choice in where they obtain supplies.

Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

- A4233 Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4234 Replacement Battery, Alkaline, J Cell, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4235 Replacement Battery, Lithium, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4236 Replacement Battery, Silver Oxide, For Use with Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each.
- A4253 Blood Glucose Test or Reagent Strips for Home Glucose Monitor, Per 50 Strips.
- A4256 Normal, Low and High Calibration Solution / Chips.
- A4258 Spring-powered Device for Lancet, Each.
- A4259 Lancets, Per Box of 100.

Effective for dates of service on or after July 1, 2013, the non-mail order fee schedule amounts for the diabetic testing supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies.

The annual covered item update will not be applied to the new national fee schedule amounts for non-mail order diabetic testing supplies. Rather, the non-mail order fee schedule amounts on the fee schedule file will be updated each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted. The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law. Since claim assignment is not

mandatory for diabetic testing supplies furnished on a non-mail order basis, beneficiaries should ask the pharmacy or supplier storefront for the supplier's charge and whether they will accept assignment of the claim before purchase.

The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 are:

- Mail Order Item (KL HCPCS modifier) - any item shipped or delivered to the beneficiary's home, regardless of the method of delivery; and
- Non-Mail Order Item (KL modifier not applicable) - any item that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

Effective July 1, 2013, only national mail order contract suppliers will be paid by Medicare for diabetic testing supplies other than those that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront. The single payment amount public use file for the national mail order competitive bidding program is available at **http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts** on the Internet. Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order diabetic testing supplies, the mail order fee schedule amounts (KL modifier) for these codes will remain on the DMEPOS fee schedule file as reference data. The mail order diabetic testing supply fee schedule amounts will be maintained and updated annually by the covered item update for use in establishing bid limits for future competitive bidding competitions.

Additional Information

The official instruction, CR 8325 issued to Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2709CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims (MM8401) (SPE)

MLN Matters® Number: MM8401
Related CR Release Date: August 9, 2013
Related CR Transmittal #: R2758CP

Related Change Request (CR) #: CR 8401
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the "*Medicare National Coverage Determination (NCD) Manual*," Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) http://clinicaltrials.gov/ website when a new study appears in the NLM Clinical Trials data base.

Make sure that your billing staffs are aware of this requirement.

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "*Requirements for Including an 8-Digit Clinical Trial Number on Claims*" is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf** on the CMS website. The MLN Matters® Article for CR5790 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf** on the CMS website.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT'.

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at **http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html** on the CMS website.

For institutional paper or direct data entry (DDE) claims, the 8-digit clinical trial number is to be placed in the value amount for paper only value code D4/DDE claim UB-04 (For Locators 39-41) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT must be placed in Filed 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below..

- Claim Adjustment Reason Code (CARC) 16: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)"
- RARC MA50: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- Group Code-Contractual Obligation (CO).

Note: *This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.*

Additional Information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2758CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Federal Spending Due to Sequestration (MM8378) (GEN)

MLN Matters® Number: MM8378
Related CR Release Date: July 25, 2013
Related CR Transmittal #: R2739CP
Related Change Request (CR) #: CR 8378
Effective Date: June 3, 2013
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8378 which informs Medicare contractors about a new Claim Adjustment Reason Code (CARC) reported when payments are reduced due to Sequestration. Make sure that your billing staffs are aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013. As a result, Medicare Fee-For-Service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. The Centers for Medicare & Medicaid services (CMS) previously assigned CARC 223 (Adjustment code for mandated Federal, State or Local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253 - Sequestration - Reduction in Federal Spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR8378.

Additional Information

The official instruction, CR 8378 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

October 2013 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8340) (DRU)

MLN Matters® Number: MM8340
Related CR Release Date: May 31, 2013
Related CR Transmittal #: R2715CP
Related Change Request (CR) #: CR 8340
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8340 which instructs Medicare contractors to download and implement the October 2013 Average Sales Price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July

2013, April 2013, January 2013, and October 2012 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 7, 2013, with dates of service October 1, 2013, through December 31, 2013. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Make sure that your billing staffs are aware of these changes.

Background

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

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

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

Files	Effective Dates of Service
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012

Note: *The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.*

Additional Information

The official instruction, CR8340 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2715CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

OPEN PAYMENTS: An Overview for Physicians and Teaching Hospitals (SE1330) (SPE)

MLN Matters® Number: SE1330
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: Not Applicable (N/A)
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition article is intended for physicians and teaching hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) conducted an MLN Connects™ National Provider Call on August 8, 2013, for physicians and teaching hospitals to give an update on the OPEN PAYMENTS program policy, with a focus on third party payments and indirect payments as well as the Physician Resource Toolkit. This article gives you an overview of the key points discussed.

OPEN PAYMENTS (*Physician Payments Sunshine Act*) requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals.

- OPEN PAYMENTS data collection began on August 1, 2013.
- Physicians and teaching hospitals may voluntarily enroll in the OPEN PAYMENTS program in order to monitor their data reported by industry.

Background

This article provides an overview of the OPEN PAYMENTS program for physicians and teaching hospitals. This information is a summary of the final rule implementing the OPEN PAYMENTS program (Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests (CMS-5060-F), codified at 42 Code of Federal Regulations (CFR) Parts 402 and 403). This summary is not intended to override or take the place of the final rule, which is the official source for requirements and information on the program.

Relationships Between Industry and Physicians are Common

Collaborations between physicians and the medical industry can be beneficial by promoting discovery and development of new technologies that improve health and/or lower costs. However, financial relationships may also influence professional judgment and conflicts of interest can potentially arise.

Section 6002 of the *Affordable Care Act* requires the establishment of a transparency program, known as OPEN PAYMENTS, which requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals, creating greater transparency around the financial relationships that occur among them.

The Final Rule, entitled "Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests," was published February 8, 2013. This rule requires manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Program (CHIP) to report annually to the Centers for Medicare and Medicaid Services (CMS) payments or transfers of value provided to physicians or teaching hospitals. In addition, manufacturers and Group Purchasing Organizations (GPOs) are required to report annually physician ownership or investment interests. CMS will publish manufacturers' and GPOs' submitted payment and ownership information on a public website.

Manufacturers and group purchasing organizations began to collect the required data on August 1, 2013, and will report the data to CMS by March 31, 2014.

OPEN PAYMENTS Objectives and Roles

The objectives of the program are to:

- Make financial relationships transparent on a national scale; and
- Give consumers the information needed to ask questions and make more informed decisions about their healthcare professionals.

CMS' Role

- Remain neutral and present the data on a public website; and
- Ensure reporting and disclosures are complete, accurate, and clear.

Industry's Role

- Collect information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their immediate family members.
- Register and submit 2013 data to CMS in the first Quarter of 2014.
- Report required annually to CMS;
- Correct disputed information.

Physicians' Role

- Voluntarily keep track of payments and transfers of value made to them and be mindful of ownership and investment interests held by themselves or immediate family.

- Voluntarily register with CMS in order to receive notifications and information submitted by industry.
- Voluntarily review information for accuracy prior to public posting and dispute potentially inaccurate data.

Impact on Physicians or Teaching Hospitals

Under the OPEN PAYMENTS program, a "physician" is any of the following types of professionals that are legally authorized by the State to practice, regardless of whether they are Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Dentistry;
- Doctor of Dental Surgery;
- Doctor of Podiatry;
- Doctor of Optometry; or
- Doctor of Chiropractic Medicine.

Note: *Medical residents are excluded from the definition of physicians for the purpose of this program, but Fellows are not excluded.*

Under the OPEN PAYMENTS program, "teaching hospitals" are hospitals that received payment for Medicare direct Graduate Medical Education (GME), Inpatient Prospective Payment System (IPPS) Indirect Medical Education (IME), or psychiatric hospital IME programs during the last calendar year for which this information is available and on the list posted annually by CMS. The teaching hospital list for OPEN PAYMENTS 2013 is posted at **http://go.cms.gov/openpayments** and will be updated annually.

As mentioned, industry will submit to CMS information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their immediate family members. Ownership or investment interest generally includes: stock, stock options other than those received as compensation, until they are exercised; partnership shares; limited liability company memberships; and loans, bonds, or other financial instruments that are secured with an entity's property or revenue or a portion of that property or revenue.

The ownership or investment interest may be direct or indirect and through debt, equity, or other means. Certain exceptions apply (See Section 403.902 Definitions in the Final Rule.).

Ownership or investment interests of an immediate family member of a physician can also trigger reporting. Immediate family member of a physician is a spouse; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother-, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Track and Review Your Information

Physicians should track all interactions they have with industry involving payments or transfers of value to ensure accuracy. Physicians and teaching hospitals are not required to register with the program. However, voluntary registration will allow physicians and teaching hospitals to review their data prior to public release. They will also be able to dispute any data thought to be incorrect.

Physicians and teaching hospitals can register and nominate an authorized representative. The information needed to register is undergoing public review and comment through the *Paperwork Reduction Act* (PRA) process. The information will be finalized and officially released after completion of the PRA process.

Physicians, teaching hospitals, and authorized representatives will be able to review and dispute information. Registration starts early 2014 and will remain open.

Physicians may initiate data disputes to correct inaccurate information any time before the end of the calendar year in which the information was publicly available. If the manufacturer or GPO can't resolve the dispute with the physician or teaching hospital and correct the data in the initial 45-day or subsequent 15-day period, the manufacturer or GPO and physician or teaching hospital should continue to seek a resolution. Corrections from disputes initiated after 45 days may not be reflected in the initial public data. Data from unresolved disputes will still be posted publicly but will be marked as "disputed." CMS will monitor the dispute and resolution process and will update the public data at least once annually.

Here is the specific physician information that is reported by the industry:

- Full legal name (as it appears in National Plan and Provider Enumeration System (NPPES);
- Primary practice and specialty;
- Primary business address;
- National Provider Identifier (NPI) as it appears in NPPES;
- State professional license number(s);
- E-mail address;
- Information about the covered product: name(s) of the related covered drug, device, biological, or medical supply;

- Information about the payment: amount, date, form, and nature of payment or other transfer of value; number of payments; and, if designated or assigned to a third party, the name of individual or entity the physician assigns the payment to; and
- How the payment was made ("Form of Payment"): Cash or cash equivalent; in kind items or services; stock or stock options or any other ownership interest; dividend, profit or other return on investment indicated to receive the payment.

In addition, the industry must report why the physician or teaching hospital received the payment ("Nature of Payment"), e.g.:

- Charitable contribution;
- Compensation for services other than consulting;
- Consulting fees;
- Current or prospective ownership or investment interest
- Direct compensation for serving as faculty or as a speaker for a medical education program (accredited and non-accredited programs);
- Education;
- Entertainment;
- Food and beverage;
- Gifts;
- Grant;
- Honoraria;
- Research;
- Royalty or license;
- Space rental or facility fees; and/or
- Travel and lodging.

Types of Payments in the Open Payment Program

This program captures payments or other transfers of value:

- Paid directly to physicians and teaching hospitals (known as "Direct Payments");
- Paid indirectly to physicians and teaching hospitals (known as "Indirect Payments"); and
- Payments designated by physicians or teaching hospitals to be paid to another party (known as Third Party Payments)

Direct payments are payments or other transfers of value provided by the applicable manufacturer or applicable group purchasing organization directly to covered recipients or physicians holding an ownership or investment interest. Here are examples of direct payments:

1. University Teaching Hospital accepts a $10,000 grant paid by check from ABC drug manufacturer on August 5, 2013. The manufacturer reports:
    - University Teaching Hospital name, address, and TIN from the teaching hospital list published annually by CMS; and
    - Payment information: form of payment, date of payment, and nature of payment.

2. Root Canal Specialty, LLC, contracts with Dr. Jane White to speak at three dental school lectures on the 5th of August, September, and October in 2013 for $5,000 per lecture. During the discussion, Dr. White will market Root Canal Specialty's prescription toothpaste, SparkleRx. The manufacturer reports:
    - Dr. Jane White information: name, business address, NPI, license number, primary and specialty type; and
    - Payment information: Form of payment, date of payment, amount of payment, nature of payment, drug information, and marketed name of the covered drug (SparkleRx).

Indirect payments are those payments or other transfers of value made by a manufacturer (or GPO) to a physician or teaching hospital through an intermediary. The manufacturer (or GPO) requires, instructs, directs, or otherwise causes the third party to provide the payment to a physician or teaching hospital. Information about the intermediary will not be reported under this program. Here are examples of indirect payments:

1. Root Canal Specialty, LLC, provides $10,000 to a dental specialty society on October 12, 2013, requesting the award to be split between the two dentists, chosen by the dental specialty society. The manufacturer reports the following information about the two dentists:
    - Name, address, NPI, license number, specialty ($5,000 will be attributed to each dentist that receives the award); and
    - Payment information: form of payment, date of payment, and nature of payment.

2. Asthma Relief, LLC, contracts with an advertisement agency to create a newsletter valued at $35, regarding cutting edge treatments for asthma. The newsletter is targeted toward top prescribers of Asthma Relief, LLC, drugs, and is provided on December 7, 2013.

    The manufacturer reports the following information about top prescribers:

- Name, address, NPI, license number, specialty ($35 will be attributed to two medical doctors that are provided the newsletter); and
- Payment information: Form of payment, date of payment, and nature of payment.

Third Party Payments are payments or other transfer of value provided to a third party at the request of or designated on behalf of a physician or teaching hospital. Here is an example of a third party payment:

Asthma Relief, LLC, provides Dr. Henry Jones with a $500 check for serving as a speaker at a round table discussing easybreathingRx and runfreeRx on August 5, 2013. Dr. Jones requests that Asthma Relief, LLC provide the compensation to a charity. The manufacturer reports the following information about the doctor:

- Dr. Henry Jones information: name, address, NPI, license number, specialty ($500 will be attributed Dr. Henry Jones);
- Payment information: form of payment, date of payment, and nature of payment, indication that the payment was designated to an entity and that the entity was a charity, as well as the name of the entity; and
- Drug information: the marketed name of the covered drugs (easybreathingRx, runfreeRx).

Compensation for speaking at a CME program is not required to be reported, if all of the following conditions are met:

- The program meets the accreditation or certification requirements and standards of the Accreditation Council for Continuing Medical Education (ACCME), the American Academy of Family Physicians (AAFP), the American Dental Association's Continuing Education Recognition Program (ADA CERP), the American Medical Association (AMA), or the American Osteopathic Association (AOA);
- The manufacturer does not directly pay the physician speaker; and
- The manufacturer does not select the physician speaker nor does it provide the third party vendor with a distinct, identifiable set of individuals to be considered as speakers for the accredited or certified continuing education program.

Other Indirect Payments associated with CME programs include meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not include in CME tuition fees.

For Certified or Accredited programs:

- For Physician-attendees: report meals, travel and lodging, and educational materials not included in CME tuition fees. Do not report tuition fees and educational materials included in CME tuition fees.
- For physician-faculty/speakers: do not report meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

For non-accredited or non-certified programs:
For physician-attendees and for physician-faculty/speakers: report meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

Items that directly benefit patients or are intended to be used by or with patients, including the value of a manufacturer's services to educate patients regarding a covered drug, device, biological, or medical supply, are not required to be reported. (See Section 403.904 Reports of payments or other transfers of value to physician or teaching hospitals of the Final Rule.) Here are two examples of educational materials:

- A manufacturer or GPO transfers a textbook to a physician or teaching hospital. This is reportable in the OPEN PAYMENTS program because it does not directly benefit patients.
- Manufacturer or GPO transfers a wall model or anatomical model to a physician or teaching hospital. This is not reportable in the OPEN PAYMENTS program because it directly benefits patients.

Physician Tools & Resources

CMS' goals include creating awareness about the OPEN PAYMENTS program among physicians, providing useful and easy to understand information about OPEN PAYMENTS and providing resources that will support physicians.

CMS is creating awareness about the OPEN PAYMENTS through:

- Hosting National Provider Calls - see the schedule of calls at **http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html** on the CMS website;
- Keeping national professional associations abreast of program developments; and
- Leveraging national publications, the Medicare Learning Network® and existing CMS contractors educational and outreach efforts.

Mobile Applications (Apps)

Two free mobile applications (Apps) to aid physicians and industry in tracking data collected for OPEN PAYMENTS are available for Apple (iOS) and Android:

- OPEN PAYMENTS Mobile for Physicians
- OPEN PAYMENTS Mobile for Industry

See MLN Matters® Special Edition Article, SE1329, for details on these Apps. SE1329 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf** on the CMS website.

CME Modules

CME modules are accessible via MedScape. They are accredited by the Accreditation Council for Continuing Medical Education. A link to CME modules is available at **http://go.cms.gov/openpayments** on the CMS website.

CME Activity #1: Are You Ready for the National Physician Payment Transparency Program?

CME Activity #2: The Physician Payment Transparency Program and Your Practice.

Educational Brochures

Brochures are available for physicians and patients about OPEN PAYMENTS. They are available on the OPEN PAYMENTS webpage at **http://go.cms.gov/openpayments**.

- Pub #11709-P: Information Physicians Can Use on: OPEN PAYMENTS (*Physician Payments Sunshine Act*)
- Pub #11710: Information Patients Can Use on: OPEN PAYMENTS

Other Publications

- MLN Matters® SE1303 "*Information on the National Physician Payment Transparency Program: Open Payments*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf** on the CMS website.
- "*The Sunshine Act - Effects on Physicians*," Agrawal, et. al., New England Journal of Medicine, NEJM 2013; 368:2054-2057, is available at **http://www.nejm.org/doi/full/10.1056/NEJMp1303523** on the Internet.

For more information, contact the Help Desk at **openpayments@cms.hhs.gov** or visit us at **http://go.cms.gov/openpayments** on the CMS website.

Overutilization of Nebulizer Medications (SE1326) (SPE)

MLN Matters® Number: SE1326
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: Not Applicable (N/A)
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Article Special Edition (SE) is intended for suppliers of Durable Medical Equipment submitting claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for supplies and services to Medicare beneficiaries.

Provider Action Needed

Durable Medical Equipment suppliers who submit claims for inhalation drugs need to know the maximum units per month that may be billed to meet medical necessity guidelines. **A table of the maximum units per month for inhalation drugs to meet medical necessity is published in Local Coverage Determinations (LCDs) for Nebulizers, which are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the Centers for Medicare & Medicaid Services (CMS) website. Once at that site, enter the key word "nebulizers" where requested and select the appropriate choice for your Geographic Area/Region to view the applicable LCD. Claims billed for units that exceed the allowable amounts will be considered an overpayment.** Make sure that your billing staffs are aware of these maximum billing amounts for inhalation drugs.

Background

This article is based on the results of an automated review of claims for inhalation drugs by the Recovery Auditors. The auditors reviewed claims with the following J codes:

- J2545 (PENTAMIDINE ISETHIONATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 300 MG);
- J7605 (ARFORMOTEROL, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 15 MICROGRAMS);
- J7606 (FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS);
- J7608 (ACETYLCYSTEINE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER GRAM);
- J7611 (ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1 MG);
- J7612 (LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG);
- J7620 (ALBUTEROL, UP TO 2.5 MG AND IPRATROPIUM BROMIDE, UP TO 0.5 MG, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME);
- J7626 (BUDESONIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 0.5 MG);
- J7631 (CROMOLYN SODIUM, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS);
- J7639 (DORNASE ALFA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM);
- J7644 (IPRATROPIUM BROMIDE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM); and
- J7669 (METAPROTERENOL SULFATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 10 MILLIGRAMS).

As previously noted, a table of the maximum units per month for inhalation drugs to meet medical necessity is published in LCDs for Nebulizers. Claims billed for units that exceed the allowable amounts will be considered an overpayment.

Here are two examples of excess billings:

- A 66 year-old male was dispensed 360 units of J7620 (Albuterol/Ipratropium Combination) on May 21, 2012. The same patient was then dispensed another 360 units of J7620 on June 11, 2012, and another 360 units of J7620 on July 2, 2012. In total, the patient received 1080 units of J7620 in three months. Per the LCDs for nebulizers, patients are allowed 186 units of J7620 per one month refill period. Based on the number of units dispensed in June and July 2012, the excess units dispensed in May were not for use in the following two months. Therefore, 174 units of J7620 dispensed May 21, 2012 are overpaid. At the time of this service the policy in effect allowed for delivery of refills no sooner than 10 days prior to the end of usage for the current product.

- A 60 year-old female was dispensed 1200 units of J7611 (Albuterol) on February 14, 2012. The same patient was dispensed 1200 units of J7611 on March 19, 2012, and an additional 1200 units on April 20, 2012. In total, the patient received 3600 units of J7611 in three months. Per the LCDs for nebulizers, patients are allowed 465 units of J7611 per one month refill period. Based on the number of units dispensed in March and April 2012, the excess units dispensed in February were not for use in the following two months. Therefore, 735 units of J7611 dispensed February 14, 2012 are overpaid. At the time of this service, the policy in effect allowed for delivery of refills no sooner than 10 days prior to the end of usage for the current product.

How You Can Improve Your Billing

You are encouraged to review the following documents in the LCD section of the Medicare Coverage Database:

- "NEBULIZERs," addresses coverage indications, limitations, and medical necessity, accessories, inhalation drugs and solutions, including a table representing the maximum milligrams/month of inhalation drugs that are reasonable and necessary for each nebulizer drug, and refill requirements. Please find this document, updated March, 15, 2013, posted by

your DME MAC (use ID of L5007, L27226, L11499, or L11488), available at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the CMS website.

- "NEBULIZERs" - Policy Article - Effective April 2013. Search for the article posted by your DME MAC (use ID of A24623, A47233, A24944, A24944, or 24942), available at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the CMS website. This document addresses coding information and general information about documentation requirements, prescription requirements and medical record information, in addition to coverage indications, limitations, and medical necessity, accessories, inhalation drugs and solutions, including a table representing the maximum milligrams/month of inhalation drugs that are reasonable and necessary for each nebulizer drug, and refill requirements.

The "*Medicare National Coverage Determinations Manual*," Chapter 1, Part 4, Coverage Determinations, Section 280.1 has a Durable Medical Equipment Reference List, and is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf** on the CMS website.

Additional Information

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

Payment Related to Prior Authorization for Power Mobility Devices (PMD) (MM8056) (MOB)

MLN Matters® Number: MM8056 Revised
Related CR Release Date: April 5, 2013
Related CR Transmittal #: R1250OTN

Related Change Request (CR) #: CR 8056
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: *This article was revised on June 28, 2013, to reflect the revised CR8056 issued on June 25. In this article, the CR release date, transmittal number and the Web address for accessing CR8056 were revised. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for Medicare Fee-For-Service (FFS) physicians/treating practitioners who prescribe Power Mobility Devices (PMDs) for Medicare beneficiaries who reside in the demonstration states of California, Texas, Florida, Michigan, Illinois, North Carolina, and New York and submit a prior authorization request to DME Medicare Administrative Contractors for a PMD.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 8056 and outlines the requirements for the PMD demonstration prior authorization initiative.

What You Need to Know

If a physician/treating practitioner submits the initial prior authorization request , the physician/treating practitioner is entitled to a G-code (G9156) incentive payment. This incentive payment is for his/her initial prior authorization request for a beneficiary only. Only one G9156 code may be billed per beneficiary per PMD even if the physician/treating practitioner must resubmit the prior authorization request. The $10 incentive payment is issued to the physician/treating practitioner on a quarterly basis by a designated Medicare Payment Contractor that issues the incentive payments for all Medicare contractors.

What You Need to Do

Make sure that your billing staffs are aware of these requirements. See the Background and Additional Information Sections of this article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) has the authority under the *Social Security Act* (Section 1834(a)(15) see **http://www.ssa.gov/OP_Home/ssact/title18/1834.htm** on the Internet) to develop and periodically update a list of Durable Medical Equipment (DME) items which are subject to prior authorization before claim payment. Under demonstration authority CMS is proposing a three year prior authorization process for PMDs in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary addresses, an initiative referred to hereafter as prior authorization. This initiative is designed as a tool to protect the Medicare Trust Fund by deterring fraudulent and abusive billing practices and make the physician or treating practitioner more accountable for the items he or she orders to prevent improper payments.

Under this PMD demonstration the physician/treating practitioner may submit the prior authorization request. If the prior authorization request is submitted by the physician/treating practitioner, the physician/treating practitioner may bill G9156. The physician/treating practitioner is entitled to a quarterly incentive payment of $10 for each G9156 code that meets all eligibility requirements. G9156 is submitted to the Medicare Administrative Contractor (A/B MACs) and/or carriers with the PMD prior authorization number. The $10 incentive payment is issued to the physician/treating practitioner on a quarterly basis.

In submitting the G9156 code, providers must also show a billed amount of $10 or the claim will reject. If the G9156 is submitted with other codes, Medicare will split the claim. Thus, providers should submit the G9156 code on an assigned claim with no other codes.

Additional Information

The official instruction, CR8056, issued to your carrier and A/B MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1250OTN.pdf** on the CMS website. MLN Matters® Article SE1231 outlines the parameters for the PMD demonstration project and may be reviewed at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1231.pdf** on the CMS website. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2013 (MM8232) (GEN)

MLN Matters® Number: MM8232 Revised
Related CR Release Date: April 5, 2013
Related CR Transmittal #: R2682CP

Related Change Request (CR) #: CR 8232
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: *This article was revised on June 20, 2013, to list 15 new ZIP codes on page 3, instead of the previous 10 new ZIP codes. All other information remains the same.*

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8232 to provide the DMEPOS July 2013 quarterly update. Change Request (CR) 8232 provides specific instructions for implementing updates to the DMEPOS Competitive Bidding Program (CBP) Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

Section 302 of the *Medicare Modernization Act of 2003* (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to

furnish certain items in competitive bidding areas, and CMS determines payment amounts resulting from the competition to replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in Competitive Bidding Areas (CBA) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando- Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) website at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf** on the Internet.

MIPPA required the competition for Round Two to occur in 2011 in 70 additional Metropolitan Statistical Areas (MSAs) and authorizes competition for national mail order items and services after 2010. The *Affordable Care Act* expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html** on the CMS website.

More information on Round Two is also available at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf** on the Internet. The information at this site includes Round Two and National Mail Order information, the latest product categories in the CBP, single payment amounts, and the ZIP codes of areas impacted by the CBP.

Updates to the ZIP Code Files:

Fifteen new ZIP codes have been added to the ZIP code file to conform with United States Postal Service ZIP code changes within CBAs:

ZIP	CBA
22350	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
31144	20075 - Atlanta-Sandy Springs-Marietta, GA
35270	20110 - Birmingham-Hoover, AL
40166	20290 - Louisville/Jefferson County, KY-IN
46197	20250 - Indianapolis-Carmel, IN
46213	20250 - Indianapolis-Carmel, IN
56935	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
56967	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
56999	20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV
64162	28140 - Kansas City, MO-KS

ZIP	CBA
72255	20280 - Little Rock-North Little Rock-Conway, AR
80038	20185 - Denver-Aurora-Broomfield, CO
84129	20430 - Salt Lake City, UT
85633	20510 - Tucson, AZ
87070	20060 - Albuquerque, NM

Additional Information

The official instruction, CR 8232, issued to your RHHI or DME/MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2682CP.pdf** on the CMS website. If you have any questions, please contact your RHHI, or DME/MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

MLN Matters® Article SE1244 is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on the Medicare DMEPOS Competitive Bidding Program at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1244.pdf** on the CMS website.

You may review the fact sheet designed to outline the requirements related to providing mail order diabetic supplies to beneficiaries who reside in a CBA as well as information detailing options for purchasing diabetic supplies on a non-mail order basis at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Mail_Order_Factsheet_ICN900924.pdf** on the CMS website.

Redaction of Health Insurance Claim Numbers (HICNs) in Medicare Redetermination Notices (MRNs) (MM8268) (GEN)

MLN Matters® Number: MM8268
Related CR Release Date: July 25, 2013
Related CR Transmittal #: R1258OTN

Related Change Request (CR) #: CR 8268
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Home Health and Hospice Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs, and A/B MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8268, which instructs the MACs to redact HICNs on all MRNs. Make sure that your billing staffs are aware of this change.

Background

Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary's HICN. To ensure that contractors protect personally identifiable information, the Centers for Medicare & Medicaid Services (CMS) is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing 5 or more values of the HICN with Xs or asterisks (*) with the last 4 or 5 digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

Additional Information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1258OTN.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update (MM8422) (GEN)

MLN Matters® Number: MM8422
Related CR Release Date: August 30, 2013
Related CR Transmittal #: R2776CP

Related Change Request (CR) #: CR 8422
Effective Date: October 1, 2013
Implementation Date: October 7, 2013

Provider Types Affected

This MLN Matters® Article is intended is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and Medicare Administrative Contractors (A/B MAC) for services to Medicare beneficiaries.

What You Need To Know

CR 8422, from which this article is taken, updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists, effective October 1, 2013; and also instructs the Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. You should make sure that your billing staffs are aware of these updates.

Background

The *Health Insurance Portability and Accountability Act (HIPAA) of 1996*, instructs health plans to be able to conduct standard electronic transactions, adopted under HIPAA, using valid standard codes. Accordingly, Medicare policy states that two standard code sets (Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) must be used for:

- Transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, (along with Group Code) to report payment adjustments; and Informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COB)).

Staff at the Centers for Medicare & Medicaid Services (CMS) usually request the CARC and RARC changes that impact Medicare, in conjunction with a policy change. If an entity other than CMS initiates a modification for a code that Medicare currently uses, contractors must either use the modified code (or another code), if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

CARC and RARC code sets are regularly updated three times a year. CR 8422 lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 262686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets.

Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR8281

These are the changes in the CARC database since the last code update CR8281. The full CARC list may be downloaded from the WPC website, available at **http://wpc-edi.com/Reference** on the Internet.

New Codes - CARC:

Code	Narrative	Effective Date
253	Sequestration - reduction in federal spending.	06/02/2013
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	06/02/2013
256	Service not payable per managed care contract.	06/02/2013
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	06/02/2013
W6	Referral not authorized by attending physician per regulatory requirement.	06/02/2013
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	06/02/2013
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	06/02/2013
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	06/02/2013

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	06/02/2013
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	06/02/2013
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	07/01/2013
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	07/01/2013
163	Attachment/other documentation referenced on the claim was not received.	06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	06/02/2013
173	Service/equipment was not prescribed by a physician.	07/01/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	07/01/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	07/01/2013
221	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	07/01/2013
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	07/01/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	07/01/2013
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	07/01/2013

Code	Modified Narrative	Effective Date
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	07/01/2013
242	Services not provided by network/primary care providers **Notes:** *This code replaces deactivated code 38*	06/02/2013
243	Services not authorized by network/primary care providers. **Notes:** *This code replaces deactivated code 38*	06/02/2013
250	The attachment/other documentation content received is inconsistent with the expected content.	06/02/2013
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	06/02/2013
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/02/2013
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply.	06/02/2013
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	06/02/2013
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013

Deactivated Codes (Also included in CR 8281) - CARC:

Code	Current Narrative	Effective Date
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	11/01/2013

Changes in RARC List Since CR8281

These are the changes in the RARC database since the last code update CR8281. The full RARC list may be downloaded from the WPC website, available at **http://wpc-edi.com/Reference** on the internet.

New Codes- RARC:

Code	Current Narrative	Effective Date
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	07/15/2013
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	07/15/2013
N576	Services not related to the specific incident/claim/accident/loss being reported.	07/15/2013
N577	Personal Injury Protection (PIP) Coverage.	07/15/2013
N578	Coverages do not apply to this loss.	07/15/2013
N579	Medical Payments Coverage (MPC).	07/15/2013
N580	Determination based on the provisions of the insurance policy.	07/15/2013
N581	Investigation of coverage eligibilty is pending.	07/15/2013
N582	Benefits suspended pending the patient's cooperation.	07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	07/15/2013
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	07/15/2013
N585	Benefits are no longer available based on a final injury settlement.	07/15/2013
N586	The injured party does not qualify for benefits.	07/15/2013
N587	Policy benefits have been exhausted.	07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.	07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	07/15/2013
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).	07/15/2013
N592	Adjusted because this is not the initial prescription oe exceeds the amount allowed for the initial prescription.	07/15/2013
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	07/15/2013
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	07/15/2013
N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	07/15/2013
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	07/15/2013
N597	Adjusted based on a medical provider's apportionment of care between related injuries and other unrelated medical conditions/injuries.	07/15/2013
N598	Health care policy coverage is primary.	07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.	07/15/2013
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.	07/15/2013
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.	07/15/2013
N602	Adjusted based on the Redbook maximum allowance.	07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.	07/15/2013
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.	07/15/2013
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.	07/15/2013

Code	Current Narrative	Effective Date
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.	07/15/2013
N607	Service provided for non-compensable condition(s).	07/15/2013
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.	07/15/2013
N609	80% of the providers billed amount is being recommended for payment according to Act 6.	07/15/2013
N610	Alert: Payment based on an appropriate level of care.	07/15/2013
N611	Claim in litigation. Contact insurer for more information.	07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	07/15/2013
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.	07/15/2013
N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).	07/15/2013
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.	07/15/2013
N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.	07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.	07/15/2013
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.	07/15/2013
N619	Coverage terminated for non-payment of premium.	07/15/2013
N620	Alert: This procedure code is for quality reporting/informational purposes only.	07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	07/15/2013
N622	Not covered based on the date of injury/accident.	07/15/2013
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	07/15/2013
N624	The associated Workers' Compensation claim has been withdrawn.	07/15/2013
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.	07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.	07/15/2013
N627	Service not payable per managed care contract.	07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	07/15/2013
N629	Reviews/documentation/notes/summaries/reports/charts not requested.	07/15/2013
N630	Referral not authorized by attending physician.	07/15/2013
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.	07/15/2013
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	07/15/2013
N633	Additional anesthesia time units are not allowed.	07/15/2013
N634	The allowance is calculated based on anesthesia time units.	07/15/2013
N635	The Allowance is calculated based on the anesthesia base units plus time.	07/15/2013
N636	Adjusted because this is reimbursable only once per injury.	07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.	07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.	07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.	07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.	07/15/2013
N641	Reimbursement has been based on the number of body areas rated.	07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.	07/15/2013
N643	The services billed are considered Covered or Non-Covered (NC) in the applicable state fee schedule.	07/15/2013
N644	Reimbursement has been made according to the bilateral procedure rule.	07/15/2013
N645	Mark-up allowance	07/15/2013
N646	Reimbursement has been adjusted based on the guidelines for an assistant.	07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).	07/15/2013
N648	Adjusted based on Stop Loss.	07/15/2013
N649	Payment based on invoice.	07/15/2013

Code	Current Narrative	Effective Date
N650	This policy was not in effect for this date of loss. No coverage is available.	07/15/2013
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	07/15/2013
N652	The date of service is before the date of loss.	07/15/2013
N653	The date of injury does not match the reported date of loss.	07/15/2013
N654	Adjusted based on achievement of maximum medical improvement (MMI).	07/15/2013
N655	Payment based on provider's geographic region.	07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.	07/15/2013
N657	This should be billed with the appropriate code for these services.	07/15/2013
N658	The billed service(s) are not considered medical expenses.	07/15/2013
N659	This item is exempt from sales tax.	07/15/2013
N660	Sales tax has been included in the reimbursement.	07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.	07/15/2013
N662	Alert: Consideration of payment will be made upon receipt of a final bill.	07/15/2013
N663	Adjusted based on an agreed amount.	07/15/2013
N664	Adjusted based on a legal settlement.	07/15/2013
N665	Services by an unlicensed provider are not reimbursable.	07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.	07/15/2013
N667	Missing prescription	07/15/2013
N668	Incomplete/invalid prescription	07/15/2013
N669	Adjusted based on the Medicare fee schedule.	07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.	07/15/2013
N672	Alert: Amount applied to Health Insurance Offset.	07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.	07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.	07/15/2013
N675	Additional information is required from the injured party.	07/15/2013
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	07/15/2013

Modified Codes - RARC:

Code	Current Narrative	Effective Date
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.	07/15/2013
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.	07/15/2013
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	07/15/2013
N441	This missed/cancelled appointment is not covered.	07/15/2013

Deactivated Codes - RARC NONE

Additional Information

The official instruction, CR 8422 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2776CP.pdf** on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Revision to the ViPS Medicare System Diagnosis Code Editing on the CMS-1500 (MM8279) (GEN)

MLN Matters® Number: MM8279
Related CR Release Date: August 5, 2013
Related CR Transmittal #: R2756CP

Related Change Request (CR) #: CR 8279
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8279 which informs Medicare DME MACs about the changes to claims processing edits which require that claims must contain correct diagnosis codes and such codes may not be truncated. In addition, all service diagnosis codes reported on the claim line must be pointed to a valid diagnosis code in the header. Claims submitted on CMS Form-1500, with dates of service on and after January 1, 2014, that contain an invalid header-level diagnosis code will be returned as unprocessable. Make sure that your billing staffs are aware of these changes.

Background

CR8279 provides instructions for handling claims submitted on a CMS Form-1500 that have an invalid, header-level, diagnosis code. In the "*Medicare Claims Processing Manual*," Chapter 1, Section 80.3.2.1.2, CMS requires that claims submitted with an incorrect or truncated diagnosis code in item 21 of the CMS Form-1500 be returned to the provider as "unprocessable." Currently, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims have been processed and replicated where an invalid diagnosis code was present in the claim header and there was no diagnosis pointer on any service line pointing to the invalid diagnosis code. The processing resulted in the passing on of invalid diagnosis codes and splitting of the claim. CR7700 corrected this issue for claims that are crossed to a Coordination of Benefits Agreement (COBA) trading partner for coordination of benefits purposes, but the issue remained for all other DMEPOS claims.

CR8279 instructs DMEPOS contractors to return as "unprocessable," claims that contain an incorrect or truncated diagnosis code in item 21 of the CMS Form-1500. When returning such claims, your DME MAC will use the following messages:

- Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.);
- Remittance Advice Remarks Code (RARC) 76 (Missing/incomplete/invalid principal diagnosis.);
- RARC MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.); and
- Group Code CO (Contractual Obligation).

Additional Information

The official instruction, CR8279 issued to your DME/MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2756CP.pdf** on the CMS website. If you have any questions, please contact your DME/MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayment (Section 50.3); Chapter 4, Debt Collection (Section 50 - 50.6 and 100.6.4) Related to Extended Repayment Schedules (ERS) (MM8347) (GEN)

MLN Matters® Number: MM8347
Related CR Release Date: August 2, 2013
Related CR Transmittal #: R224FM

Related Change Request (CR) #: CR 8347
Effective Date: September 3, 2013
Implementation Date: September 3, 2013

Provider Types Affected

This MLN Matters® article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Post Hospital Home Health (HHH), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs),) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8347 is a policy change that streamlines the Extended Repayment Schedules (ERS) process by updating the policy language and standard practices. See the Key Points section of this article for specifics.

Background

Overpayments are Medicare payments to a provider that are in excess of amounts due and payable under the statute and regulations. When an overpayment is determined, a demand letter is sent requesting repayment. A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" for the provider, the provider may request an ERS at any time the overpayment is outstanding. Medicare Contractors and/or Centers for Medicare & Medicaid Services (CMS) staff will review the request to determine if extending a repayment schedule is justified.

Key Points

The following points are based on the revised manual, "*Medicare Financial Management*," Chapter 4 -Debt Collection.

- Medicare contractors are charged with establishing an ERS formerly called an Extended Repayment Plan (ERP). Contractors must process ERS requests within 30 days of receipt and make certain providers complete all instructions. Contractors are required to post information and instructions on their websites and supply paper copies if requested.
- Your Medicare contractor will approve/disapprove an ERS request from 6 months up to 36 months and the CMS for an ERS up to 60 months - again within 30 days of receipt.
- Your Medicare contractor will not refund monies recouped during the review process. The recouped amounts will be applied to the overpayment.
- Contractors will notify a provider of approval or no approval within 5 days of decision.
- Contractors will recoup ERS payments from a provider's future Medicare payment, unless the contractor determines there is a valid reason to send in a check.
- Chapter 4, Section 100.6.4 details the ERS process that occurs if a request is received by the Recovery Audit Contractor (RAC) from a provider. The point of contact information for the ERS at the RAC location will be provided in a separate instruction.

Additional Information

The official instruction, CR8347 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R224FM.pdf** on the CMS website.
You may review CR7688 for an explanation of the policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date at: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7688.pdf** on the CMS website.

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

Revisions to the Medicare Benefit Policy Manual, Chapter 11 (End Stage Renal Disease (ESRD)) to Reflect the Implementation of the ESRD Prospective Payment System (PPS) (MM8261) (SPE)

MLN Matters® Number: MM8261
Related CR Release Date: June 7, 2013
Related CR Transmittal #: R171BP

Related Change Request (CR) #: CR 8261
Effective Date: January 1, 2011
Implementation Date: September 9, 2013

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare contractors, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for End Stage Renal Disease (ESRD) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8261 which updates the "*Medicare Benefit Policy Manual*" to reflect implementation of the ESRD Prospective Payment System. This System has been covered in prior articles and publications and the Centers for Medicare & Medicaid Services (CMS) is now updating their official manual to reflect this implementation.

Background

Effective January 1, 2011, CMS implemented the ESRD PPS, which provides a single payment to ESRD facilities, including hospital-based and independent facilities. The payment includes all items and services used in furnishing outpatient dialysis services including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services.

(CR8261 updates the "*Medicare Benefit Policy Manual*," Chapter 11- End Stage Renal Disease (ESRD) to reflect implementation of the ESRD PPS. A copy of the revised Chapter 11-End Stage Renal Disease (ESRD) is included as an attachment to CR 8261.

Additional Information

The official instruction, CR 8261 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R171BP.pdf** on the CMS website.

See the ESRD payment page at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html** on the CMS website for specific ESRD PPS downloads and related links.

MLN matters article MM7064 "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services", explains PPS reimbursement for part B ESRD services. The article is at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7064.pdf** on the CMS website.

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

Fee Schedule Updates (GEN)

The 2013 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. This quarter the following notices have been posted:

- 3rd Quarter 2013 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2013 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2013 Oral Anticancer Drug Fees

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

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

MLN Connects ™ Provider e-News Links (GEN)

August

MLN Connects ™ Provider e-News for Thursday, August 29, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-29-eNews.pdf

MLN Connects ™ Provider e-News for Thursday, August 22, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-22-eNews.pdf

MLN Connects ™ Provider e-News for Thursday, August 15, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-15-enews.pdf

MLN Connects ™ Provider e-News for Thursday, August 8, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-08-enews.pdf

MLN Connects ™ Provider e-News for Thursday, August 1, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-01-enews.pdf

July

MLN Connects ™ Provider e-News for Thursday, July 25, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-25-Enews.pdf

MLN Connects ™ Provider e-News for Thursday, July 18, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-18Enews.pdf

MLN Connects ™ Provider e-News for Thursday, July 11, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-11-Enews.pdf

MLN Connects ™ Provider e-News for Thursday, July 4, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-04-Enews.pdf

June

MLN Connects ™ Provider e-News for Thursday, June 27, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-27Enews.pdf

CMS e-News for Thursday, June 20, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-20Enews.pdf

CMS e-News for Thursday, June 13, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-13Enews.pdf

CMS e-News for Thursday, June 6, 2013
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-06-Enews.pdf

CMS News Flash (GEN)

New and Revised products from the Medicare Learning Network® (MLN)

- "*Annual Wellness Visit*"
  Podcast, ICN 908726, Downloadable only.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/2013-05-29-awv.html

- "*Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Health Care Professionals Informed*"
  Fact Sheet, ICN 006785, Downloadable only
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf

- "*DMEPOS Competitive Bidding Program: Non-Contract Supplier*"
  Fact Sheet, ICN 900925, Downloadable only
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME-Noncontract-Factsheet-ICN900925.pdf

- "*DMEPOS Quality Standards*"
  Booklet, ICN 905709, Downloadable only
  http://www.cms.gov/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf

- "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies*"
  Fact Sheet, ICN 905711, Downloadable only
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DMEPOS_Pharm_Factsheet_ICN905711.pdf

- "*General Equivalence Mappings Frequently Asked Questions*"
  Booklet, ICN 901743, Downloadable only
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf

- "*Health Care Professional Frequently Used Web Pages*"
  Educational Tool, ICN 908466, Downloadable only (Posted June 2013)
  http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/FrequentlyUsedWebpages.pdf

- "*ICD-10-CM/PCS Myths and Facts*"
  Fact Sheet, ICN 902143, Downloadable only
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10MythsandFacts.pdf

- "*ICD-10-CM/PCS The Next Generation of Coding*"
  Fact Sheet, ICN 901044, Downloadable and Hard Copy
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10Overview.pdf

- "*Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 2]*"
  Educational Tool, ICN 908424, Downloadable or Hard Copy
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908424.pdf

- "*The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Traveling Beneficiary*"
  Fact Sheet, ICN 904484, Downloadable only
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Travel_Bene_Factsheet_ICN904484.pdf

- "*Screening Pap Test,*"
  Booklet, ICN 907791, Downloadable only (August 2012)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-Pap-Tests-Booklet-ICN907791.pdf

Other CMS New Flash Messages

Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf** and start receiving updates immediately!

"***The Medicare Billing Certificate Program for Part B Providers***" Web-Based Training Program (C00164) is revised and is now available. This WBT is designed to provide education on Part B of the Medicare program. It includes required web-based training courses and readings and a helpful list of resources. Upon successful completion of this program, you will receive a certificate in Medicare billing for Part B providers from the Centers for Medicare & Medicaid Services. To access the WBT, go to **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html** and click on "*Web-Based Training Courses*" under "*Related Links*" at the bottom of the web page.

In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the "*mailing list for referral agents*" (**https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814**) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MAC Satisfaction Indicator (MSI) - The Centers for Medicare & Medicaid Services (CMS) is launching a new instrument for 2013 called the MAC Satisfaction Indicator (MSI). The MSI is a tool that measures providers' satisfaction with their Medicare claims administrative contractor(s). Your input will help your MAC to improve the services that they offer you. Participation is voluntary, but you must register to participate. Complete the application at **https://adobeformscentral.com/?f=eMRKPqaWpqMxNOmTQpSKDA** on the Internet. For more information, visit **http://www.cms.gov/Medicare/Medicare-Contracting/MSI** on the CMS website.

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

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Appropriate Coding and Billing of Lower Limb Prosthetic Covers and Covering Systems (O&P)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received a high volume of submitted claims for lower limb prosthetic covers (L5704-L5707) and protective covering systems (L5962, L5964, and L5966) for the same lower limb prosthesis. The need for both of these is rare, and this article is intended to educate suppliers and providers about the occasions where both of these are considered to be reasonable and necessary.

Lower limb prosthetic covers (L5704-L5707) are complete products and afford shape, protection and waterproofing for normal daily usage of the prosthesis. They offer sufficient protection and weatherproofing for patients who require lower limb prosthetics.

Protective outer surface covering systems (L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of that which is afforded by L5704-L5707. They are not covered for cosmetic or convenience reasons, or for everyday usage in a typical environment. This type of product is separate from the covering that is already reimbursed as part of L5704-L5707 and is rarely necessary.

Documentation to support medical necessity of a protective outer surface covering system (L5962, L5964, and L5966) must indicate the type of extraordinary activities that would justify the need for extra protection afforded by this highly durable item. Again, this type of extra protection is not routinely necessary.

When billing for the protective outer surface covering systems (L5962, L5964 and L5966), information regarding the type of protective cover provided (i.e., manufacturer name, make, model or type) must be included on claims in order to ensure correct coding.

Suppliers should utilize the Medicare Pricing, Data Analysis and Coding Contractor (PDAC) Web site (**https://www.dmepdac.com/dmecs/index.html**) to ensure accurate coding of DMEPOS claims.

Billing Reminder - AFO/KAFO Prefabricated Base Orthoses and Custom-Fabricated Additions (O&P)

Recently errors in billing for combinations of custom-fabricated orthotic additions with prefabricated base orthoses have been identified.

The Coding Guideline sections of the policy article for Ankle-Foot/Knee-Ankle-Foot Orthoses and Knee Orthoses define prefabricated and custom-fabricated as follows:

> *A prefabricated orthosis is one, which is manufactured in quantity without a specific beneficiary in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e.,*

custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

A custom-fabricated orthosis is one, which is individually made for a specific beneficiary starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

It is inherent in the definition of prefabricated that a particular item is complete. Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and will be denied as not reasonable and necessary if billed with prefabricated base orthotics.

Refer to the LCDs and related Policy Articles for Ankle-Foot/Knee-Ankle-Foot Orthoses and Knee Orthoses for additional information about coverage, documentation and billing for these items.

Coverage Reminder - High Liter-Flow Oxygen (>4 LPM) (OXY)

Recent reviews of high liter-flow oxygen claims have identified errors in billing for high liter-flow and portable oxygen systems. This article will review basic coverage and documentation requirements.

Oxygen and oxygen equipment is eligible for payment for beneficiaries who have a qualifying medical condition that results in hypoxemia (low blood oxygen levels). A stationary oxygen system is the equipment covered when a beneficiary qualifies. Additional payment is available for a portable system if it is necessary to move about inside the beneficiary's home.

There are three payment levels for oxygen based upon the liter-flow prescribed:

- Less than 1 lpm - pays less than the standard payment amount
- 1-4 lpm - is the standard payment amount
- Greater than 4 lpm - pays more than the standard payment amount

In order to qualify for the highest payment level, greater than 4 lpm, a second blood oxygen test must be obtained while the beneficiary is breathing oxygen at 4 lpm. A qualifying test result must be obtained while at that liter-flow in order to justify payment at the higher rate. If the beneficiary qualifies for payment at the higher rate, there is no additional payment for a portable oxygen system. The INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY section of the LCD states:

> LITER FLOW GREATER THAN 4 LPM:
> If basic oxygen coverage criteria have been met, **a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the beneficiary is on 4 or more LPM meets Group I or II criteria.** If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. (Refer to related Policy Article for additional information on payment for greater than 4 LPM oxygen.) (emphasis added)

The NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article states:

> Payment for stationary equipment is increased for beneficiaries requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for beneficiaries requiring less than 1 LPM. **If a beneficiary qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, payment will be made for the stationary system at the higher allowance, but not for the portable system. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied as not separately payable.** (emphasis added)

Modifiers QF and QG must be used when submitting the claim.

- QF - Prescribed amount of oxygen is greater than 4 liter per minute (LPM) and portable oxygen is prescribed
- QG - Prescribed amount of oxygen is greater than 4 liters per minute (LPM)

Refer to the Oxygen and Oxygen Equipment LCD, related Policy Article and *Supplier Manual* for additional information about coverage and documentation requirements.

Coverage Reminder - Safety Lancets Non-covered (SPE)

Questions about Medicare coverage of safety lancets used in assisted living facilities have recently arisen. Safety Lancets are devices used to obtain samples for conducting blood glucose monitoring. They are safety-engineered with features designed to safeguard users from blood-borne pathogens. The DME MACs have been told that Occupational Safety and Health Administration (OSHA) regulations require that residential settings, such as group homes or assisted living facilities, provide lancets with safety-engineered features in order to safeguard their employees.

Safety lancets are considered to be precautionary items (i.e. they are necessary for the safety of the user when assisting a patient in using a home blood glucose monitor) and are not covered regardless of the setting or who is making use of them. Safety lancets are not needed in order to avoid an adverse medical outcome on the beneficiary who requires the test and are therefore not needed for the beneficiary's personal home blood glucose monitor to function. Services provided in group homes, assisted living facilities, and other similar residential facilities that furnish personal assistance or custodial care are not covered by Medicare. The cost of furnishing safety lancets in order to safeguard employees is part of the cost of providing assisted living services and is the responsibility of the facility. DMEPOS suppliers are not required to furnish safety lancets under Medicare payment rules since these items fall outside the scope of the DME benefit.

Refer to the Glucose Monitors Local Coverage Determination and the related Policy Article for additional information.

Documentation Reminder - Glucose Monitor Logs for High-Utilization Claims (SPE)

The Home Blood Glucose Monitor LCD requires that certain information be documented for beneficiaries testing at high frequency. One key item is evidence that the beneficiary is actually testing at the prescribed high frequency. Numerous methods may be used to gather this information. One common method has been for the DMEPOS supplier to collect the beneficiary testing logs.

In the past, the DMEPOS supplier was allowed to directly collect testing logs from the beneficiary and submit them to the DME MAC when requested as part of a claim review. In November 2012, the Home Blood Glucose Monitor LCD was revised, eliminating the option for the DMEPOS supplier to directly collect the testing log. This option was removed as it violates the *CMS Program Integrity Manual* (PIM) section 5.7 requirement for documentation of medical necessity. The section specifies that information justifying coverage must be part of the medical record. This section explicitly excludes DMEPOS supplier collected information from being sufficient alone to justify coverage, even if signed by the physician. Supplier collected information, even if signed by the physician must be corroborated by information directly contained in the medical record. PIM 5.7 says, in relevant part:

> However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).

The November 2012 LCD was revised to remove statements in previous versions of the policy allowing for direct supplier collection of testing logs. The current LCD INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY section now states:

High Utilization

- For a beneficiary who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a) - (c) below are met.
- For a beneficiary who is currently being treated with insulin injections, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a) - (c) below are met.

a. Basic coverage criteria (1)-(2) listed above for all home glucose monitors and related accessories and supplies are met; and,
b. The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary; and,
c. If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.*

*Note that there is now NO mention of the supplier collection of testing logs. The requirement is that the evidence of beneficiary testing must be in the medical record.

The POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section states:

Additional documentation requirements apply to:

- A beneficiary who is not insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day; or,
- A beneficiary who is insulin-treated (KX modifier present) and whose prescribed frequency of testing is more often than three times per day.

Additional documentation in the medical record must demonstrate that the basic coverage criteria (1) - (2) described in the Indications and Limitations of Coverage and/or Medical Necessity section of this LCD have been met and that the additional criteria (a) - (c) for high utilization have been met, including the evaluation of the beneficiary's glucose control necessitating quantities of test strips and lancets that exceed the usual utilization guidelines (criterion b). This information does not have to be submitted with the claim but must be available upon request.

In summary, (1) DMEPOS suppliers may not directly collect beneficiary testing information (logs) and submit them to the DME MAC to demonstrate compliance with this criterion and (2) DMEPOS suppliers may not directly collect beneficiary testing information (logs) and forward it to the treating physician for inclusion into the medical record to demonstrate compliance with this requirement.

Refer to the Glucose Monitors LCD, related Policy Article and *Supplier Manual* for additional information.

Documentation Reminders: Immunosuppressive Drugs (DRU)

Claims review by both the DME MACs and the Comprehensive Error Rate Testing (CERT) Review Contractor show a high percentage of documentation errors involving claims for immunosuppressive drugs. As a result many of the DME MACS are, or will be, conducting a review of immunosuppressive drug claims. Some of the most common errors identified by claim reviewers relate to physician records including:

Detailed Written Orders:

- Copy of detailed written order was not provided;
- Detailed written order was illegible (blackened and/or blurred)
- The order was invalid because it was missing required elements. Required elements for orders include:
  - Beneficiary's name
  - Name of drug
  - Dosage
  - Quantity to be dispensed
  - Route of administration
  - Frequency of administration
  - Physician's name
  - Refill instructions
  - Physician signature and date
  - The start date of the order - only required if the start date is different than the signature date

- Physician did not personally date his/her signature; and
- Items were delivered prior to obtaining a detailed written order and no written documentation of a dispensing order was provided.

Medical Records:

- Copy of pertinent medical records was not provided;
- Medical records did not document that the drug was included in the physician's plan of care for the beneficiary;
- Records failed to document continued use and/or medical need for the drug;
- The name of the transplant center was not provided;
- Records are missing a signature or it is illegible; and
- Records provided did not document a transplant.

Physicians are reminded that while immunosuppressive drugs are often prescribed for various medical indications, Medicare's coverage of immunosuppressive drugs is narrowly defined and closely regulated by Medicare statute and benefit category language. Title XVIII of the *Social Security Act*, §1861(s)(2)(J) provides for coverage of immunosuppressive drugs; however, coverage is limited solely to usage following specific organ transplants. Regulations regarding coverage and payment of immunosuppressive drugs are found in 42 CFR 410.30 and the Centers for Medicare & Medicaid Services (CMS) *Benefit Policy Manual* (Internet-Only Manual, Publication 100-2), Chapter 15, Section 50.5.1 and *Claims Processing Manual* (Internet-Only Manual, Publication 100-4), Chapter 17, Section 80.3.

As a result of the statutory and benefit language, immunosuppressive drugs are eligible for reimbursement only when all of the following criteria are met:

I. Immunosuppressive drugs are prescribed following either:

   A. Kidney (V42.0), heart (V42.1), liver (V42.7), bone marrow (V42.81)/stem cell (V42.82), lung (V42.6), or heart/lung (V42.1 and V42.6) transplant; or,

   B. Whole organ pancreas (V42.83) transplant performed concurrent with or subsequent to a kidney transplant (V42.0) because of diabetic nephropathy (performed on or after July 1, 1999); or,

   C. Intestinal transplant (V42.84) (performed on or after April 1, 2001); or,

   D. Pancreatic islet cell transplant (V42.89) or partial pancreatic tissue transplantation (V42.89) performed on or after October 1, 2004 that is conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial; or,

   E. Pancreas transplants alone (performed on or after April 26, 2006) that meet the following criteria:
      1. The transplant is performed in a facility that is Medicare-approved for kidney transplantation; and
      2. Beneficiary must have a diagnosis of type I diabetes and:
         a. Must be beta cell autoantibody positive; or,
         b. Must demonstrate insulinopenia, (fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method). A fasting glucose must be obtained when performing a fasting C-peptide determination. Fasting C-peptide levels are considered valid when a concurrently obtained fasting glucose is <225 mg/dL; and,
      3. Must have a history of labile (brittle or medically-uncontrollable) insulin-dependent diabetes mellitus resulting in documented recurrent, severe, acutely life-threatening metabolic complications requiring hospitalization(s). Complications may include frequent hypoglycemia where the beneficiary is unaware, recurring severe ketoacidosis, or recurring severe hypoglycemic attacks; and,
      4. Must have been under the care of an endocrinologist and have clinical documentation denoting optimal and intensive management was provided for at least 12 months, having received the most medically-recognized advanced insulin formulations and delivery systems; and,
      5. Must demonstrate being able to emotionally and mentally understand the significant risks associated with surgery and be able to effectively manage the lifelong need for immunosuppression; and,
      6. Must otherwise be a suitable candidate for transplantation; and

II. The transplant met Medicare coverage criteria in effect at the time (e.g., approved facility for kidney, heart, intestinal, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria; etc.); and,

III. The beneficiary was enrolled in Medicare Part A at the time of the transplant; and,

IV. The beneficiary is enrolled in Medicare Part B at the time that the drugs are dispensed; and,

V. The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.

If criteria I-V are not met, the drug(s) will be denied as noncovered.

If criteria I, II, and III are met, the transplant is considered a "covered transplant" for purposes of this policy whether payment for the transplant was made by Medicare or by another insurer.

For questions regarding documentation requirements for Immunosuppressive Drug claims, physicians and suppliers should refer to the Immunosuppressive Drugs LCD and related Policy Article for their respective DME MAC.

Glucose Monitors and Supplies Dear Physician Letter (July 2013) (SPE)

Dear Physician,

Glucose monitor supplies have consistently been one of the highest sources of errors in medical reviews performed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Comprehensive Error Rate Testing (CERT) contractor. We know that ordering physicians do work to document the medical necessity for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The following information is intended to provide you with guidance on Medicare's coverage and documentation requirements for glucose monitors and testing supplies.

COVERAGE

Glucose monitors and related supplies are covered for patients with diabetes (ICD-9 Codes 249.00 - 250.93) if they or their caregiver can be trained to use the prescribed device appropriately.

The Glucose Monitors Local Coverage Determinations (LCDs) of the DME MACs define the quantity of test strips and lancets that are covered, if the basic criterion above is met.

Treatment regimen	Basic coverage Test strips and lancets
Insulin treated	300 per 3 months
Non-insulin treated	100 per 3 months

Additional quantities of test strips can be considered for coverage **if they are documented to be medically necessary** - see following section.

Coverage is also provided for a lancing device, calibration solution, and replacement batteries.

MEDICAL NECESSITY DOCUMENTATION

CMS expects that physician records will reflect the care provided to the patient including evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC.

As noted below in the Orders section, standard glucose monitors (HCPCS code E0607) require a written order prior to delivery and a face-to-face (F2F) examination. The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. Both the written order and the F2F examination must be provided to the supplier before they can dispense the glucose monitor to the patient.

There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and,
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:

- Justification for testing frequency; and,
- Evidence of the patient's use at this frequency.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
  - Names, dosages, and timing of administration of medications used to treat the diabetes;
  - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
  - Review of beneficiary-maintained log of glucose testing values;
  - Changes in the patient's treatment regimen as a result of glucose testing results review;
  - Dosage adjustments that the patient should make on their own based on self-testing results;
  - Laboratory tests indicating level of glycemic control (e.g., hemoglobin A1C);
  - Other therapeutic interventions and results.

  Not every patient's medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results
  - Information about medication dosage adjustments related to the results is also helpful.

ORDERS

For initial dispensing of a standard glucose monitors (code E0607), the supplier must receive a written order prior to delivery of the item to the beneficiary. In addition, you must conduct a face-to-face (F2F) examination within six (6) months prior to the date of the written order. Both of these documents must be received by the supplier prior to dispensing the item to your patient. This detailed written order must contain, at a minimum, the following elements:

1. Beneficiary's name,
2. Physician's Name
3. Date of the order and the start date, if start date is different from the date of the order
4. Detailed description of the item
5. The prescribing practitioner's National Provider Identifier (NPI),
6. The signature of the ordering practitioner
7. Signature date

Note that testing supplies (e.g., lancets, test strips, control solutions, batteries) are not subject to the written order prior to delivery and F2F requirements. For testing supplies, the written order must contain the following elements:

1. Beneficiary's name
2. Prescribing physician's name
3. Item(s) to be dispensed
4. Frequency of testing ("as needed" is not acceptable);
5. Quantity to be dispensed
6. Number of refills
7. Physician's signature
8. Signature date
9. Start date of order - only required if start date is different than signature date.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing, a change in supplier, or a new, treating physician.

If the supplier provides you with a prepared "written order" for your signature and date, you should inspect this document carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of your explicit approval.

This article is only intended to be a general summary. It is not intended to take the place of the written law, regulations, national or local coverage determinations. The LCD for Glucose Monitors can be found in the Medicare Coverage Database on the CMS web site at **http://www.cms.gov/mcd/search.asp?from2=search.asp&** (search "Glucose Monitors").

Sincerely,

Paul J. Hughes, MD
Medical Director, DME MAC, Jurisdiction A
NHIC, Corp.

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C
CGS Administrators, LLC

Stacey V. Brennan, MD, FAAFP
Medical Director, DME MAC, Jurisdiction B
National Government Services

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC, Jurisdiction D
Noridian Healthcare Solutions

Knee Orthoses Local Coverage Determination - Covered Diagnoses Update (O&P)

The Knee Orthoses local coverage determination (LCD) has been revised with the addition of diagnosis 727.66, Rupture of tendon, nontraumatic, site-patellar tendon.

Effective for dates of service on or after August 15, 2013, ICD-9 code 727.66 is covered for HCPCS codes L1830, L1832, L1834, L1843, L1844, L1845, and L1846.

Refer to the Knee Orthoses LCD and Policy Article for complete information concerning coverage criteria, coding guidelines, and documentation requirements.

LCD and Policy Article Revisions Summary for August 29, 2013 (GEN)

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

Manual Wheelchair Bases

LCD

Revision Effective Date: 10/01/2013
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
- Added: K0008
- Added: E1037 - E1039 and K0008 coverage criteria

HCPCS CODES:
- Added: E1037 - E1039 and K0008

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
- Added: K0008 to ADMC eligible
- Added: E1037 - E1039 and K0008 requirements

Policy Article

Revision Effective Date: 10/01/2013
CODING GUIDELINES:
- Added: K0008 description and reference
- Removed: K0108 billing method for wheelchair modification

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 05/29/2013 (August 2013 Publication)
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Coverage for use with alemtuzumab, azacitidine, bendamustine, carboplatin, clofarabine, cytarabine, daunorubicin, idarubicin, ifosfamide, irinotecan and oxaliplatin

Power Mobility Devices

LCD

Revision Effective Date: 10/01/2013
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Clarification of need for WOPD
Added: K0013 under general coverage criteria
HCPCS Codes:
Added: K0013
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: K0013 documentation requirements
MISCELLANEOUS:
Added: K0013 to ADMC eligible

Policy Article

Revision Effective Date: 10/01/2013
CODING GUIDELINES:
Added: K0013 customized motorized/power wheelchair verbiage
MISCELLANEOUS:
Added: K0013 is not subject to PDAC code verification

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

LCD and Policy Article Revisions Summary for July 5, 2013 (GEN)

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

Glucose Monitors

LCD

Revision Effective Date: 08/01/2013
DOCUMENTATION REQUIREMENTS:
Revised: Elements of detailed written order for items provided on periodic basis
Revised: Continued use requirement for usual utilization vs high utilization
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: High utilization requirements

Hospital Beds and Accessories

LCD

Revision Effective Date: 08/01/2013
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: From criterion 3, the requirement of "Pillows or wedges must have been considered and ruled out"

Surgical Dressings

Policy Article

Revision Effective Date: 06/01/2013

CODING GUIDELINES:

Added: Reference to PDAC coding verification requirement for A6021, A6022, A6023 and A6024

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

LCD and Policy Article Revisions Summary for June 27, 2013 (GEN)

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

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 08/01/2013

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Clarified general recertification issues

Added: Refill allowance and bundling instructions

Removed: Refill monitoring requirements

DOCUMENTATION REQUIREMENTS:

Removed: Refill documentation requirements

Oral Anticancer Drugs

Policy Article

Revision Effective Date: 06/01/2013

CODING INFORMATION:

Added: ICD-9 diagnoses for most recent National Comprehensive Cancer Network (NCCN) updates: 152.0-152.2, 152.8, 152.9, 158.9, 187.1-187.4, 187.8, 187.9, 189.0, 189.1, 199.0, 199.1, 251.1, 251.4, 251.8, V10.52 for capecitabine; 158.9, 238.77, V23.89 for cyclophosphamide; 198.4, 235.2, 235.5, 238.77, V10.00 for etoposide; 204.80, 204.82 for Fludarabine Phosphate; 199.0, 199.1, V10.79 for melphalan; 187.9, 196.0, 198.89 for methotrexate; 157.0, 157.2, 157.9, 179, 180.0, 182.0, 182.1, 182.8, 202.10, 202.18, 202.20, 202.28, 209.21, 235.5, 251.1, 251.4, 251.8, V16.49 for temozolomide; 158.9, 198.4 for Topotecan

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

LCD for Hospital Beds and Equipment - Documentation Reminder (MOB)

The Comprehensive Error Rate Testing (CERT) Contractor reviews claims and identifies errors in compliance with Medicare payment rules. These errors are reported as the CERT Error Rate. The DME MACs provide information about these errors and actions that may be undertaken to reduce or avoid them.

The highest volume of CERT errors occurring for hospital beds and equipment claims are due to missing or incomplete documentation to demonstrate that the following LCD reasonable and necessary (R&N) criteria were met:

A fixed height hospital bed (E0250, E0251, E0290, E0291, and E0328) is covered if one or more of the following criteria (1-4) are met:

1. The beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, or
4. The beneficiary requires traction equipment, which can only be attached to a hospital bed.

A variable height hospital bed (E0255, E0256, E0292, and E0293) is covered if the beneficiary meets one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the beneficiary meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

As these are rental items, there must be evidence of continued medical need and on-going medical management periodically (within 12 months of the date of service) noted in the medical record in order to document sufficient physician oversight of the underlying medical conditions to justify continued rental reimbursement.

Information from the medical record is necessary to provide evidence that the policy requirements are met. This means that DMEPOS suppliers must develop effective communication with their referral sources to ensure that the policy requirements are understood and sufficient information is recorded to justify payment.

The DME MACs have developed a "Dear Physician" letter describing Medicare's documentation requirements. This letter is available on each DME MAC web site. In addition, we suggest that furnishing a copy of the LCD may be helpful.

Suppliers are reminded to monitor use of these items and to discontinue billing if the beneficiary stops using the item. In the event of a claim review, evidence of continued use may be requested. This information may come from the supplier-created records.

Refer to the LCD, related Policy Article and *Supplier Manual* for additional information on coverage and documentation.

Policy Update - TENS (E0720, E0730) Additional KX Modifier Requirements and CMN Requirement Reinstated for Chronic Low back Pain Diagnosis (SPE)

In the recent revision of the TENS LCD (effective 06/08/2012), the CMN requirement was removed for claims associated with chronic low back pain (CLBP) diagnoses. The requirement had been removed to simplify the documentation requirements for this group. The removal of the requirement for this subset of claims caused denials at CWF. To resolve these denials the CMN requirement for TENS (E0720, E0730) is reinstated for CLBP effective for claims with dates of service on or after 10/01/2013.

Please note this revision of the LCD also requires use of the KX modifier for HCPCS codes E0720 and E0730 (in addition to code E0731) when any one of the coverage criteria, I-III, in the Coverage Indications, Limitations and/or Medical Necessity section are met.

Additionally, the ASSOCIATED INFORMATION section of the LCD and the NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related policy article for TENS has been updated to include face to face encounter requirements as outlined in Section 6407 of the Affordable Care Act.

Refer to the TENS LCD and related Policy Article for additional information.

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

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

DME MAC A Medical Review has been performing a service-specific Documentation Compliance Review (DCR) of HCPCS Codes A4253 (Blood glucose test strips) claims. This type of review is conducted when data analysis indicates there is a pattern of insufficient documentation in a product category.

This review was initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

Documentation Requested

The following documentation is requested to perform the DCR:

- Detailed written order for the Glucose testing supplies, for the billed dates of service
- Proof of beneficiary testing blood glucose (if billing quantities above the LCD limits)
- Valid Proof of Delivery
- A valid proof of request for refill of glucose testing supplies

Current Review Results

These findings are for claims reviewed from April 01, 2013 through June 30, 2013:

- The review involved DCRs of 11,061 claims.
- Of the 11,061 claims reviewed, 6,003 claims were denied resulting in a claim denial rate of 54%.
- An additional 2,065 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Primary Reasons for Denial

Based on review of the documentation received, the following are the primary reasons for denial:

- Missing test logs/Proof of testing frequency (when billing quantities above the LCD limits)
- Proof of delivery missing or incomplete
- Request for refill incomplete (primarily) or missing; ex. quantity remaining missing

Next Step

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

Educational References

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

- Items Provided on a Recurring Basis and Request for Refill Requirements - Revised - August 2012
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/083112_refill.pdf
- Coverage Reminder - Requirements for High Utilization of Glucose Monitor Strips and Lancets
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/031513_bgm.pdf
- Glucose Monitor LCD (L11530) and Related Policy Article (A33614)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

- The *DME MAC Jurisdiction A Supplier Manual* "Welcome Page" provides valuable information to the CMS Web sites. Chapter 10: includes information regarding documentation requirements.
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- DME MAC A Glucose Monitor Tutorial
  http://www.medicarenhic.com/dme/dme-eduonline.shtml#tutorials
- DME MAC A Glucose Documentation Podcast
  http://www.medicarenhic.com/dme/dme-eduonline.shtml#podcast
- Results of Documentation Compliance Review (DCR) of Claims for HCPCS A4253
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/050313_a4253.pdf
- Documentation Reminder - Glucose Monitor Logs for High-Utilization Claims
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/071213_glucose.pdf
- Glucose Monitors and Supplies - Dear Physician Letter
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/glucose_phy_letter.pdf

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

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

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

Documentation Requested

The following documentation is requested to perform the DCR:

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

Current Review Results

These findings are for claims reviewed from April 01, 2013 through June 30, 2013:

- The review involved DCRs of 5,401 claims.
- Of the 5,401 claims reviewed, 3,405 claims were denied resulting in a claim denial rate of 63%.
- An additional 85 claims were denied during this time frame because responses were not received for the Additional Documentation Requests (ADR).

Primary Reasons for Denial

Based on review of the documentation received, the following are the primary reasons for denial:

- No documentation of the treating physician visit 30 days prior to the Initial CMN was submitted.
- No documentation of the beneficiary's most recent blood gas study/oxygen saturation test was submitted.

- Proof of delivery was not submitted or was incomplete.

Next Step

Based on the results of this DCR, DME MAC A will continue to perform DCRs on HCPCS E1390.

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

Educational References

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

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- The *DME MAC Jurisdiction A Supplier Manual* "Welcome Page" provides valuable information to the CMS Web sites. Chapter 10: includes information regarding documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Oxygen & Supplies
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word oxygen)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: May 17, 2013; February 08, 2013; October 12, 2012; June 29, 2012; March 2, 2012; November 04, 2011; August 26, 2011; November 05, 2010; and June 09, 2010
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Results of Widespread Prepayment Complex Review for Lower Limb Prostheses (O&P)

Historical Review Results

A widespread complex medical review was performed for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This review resulted in a Charge Denial Rate (CDR) of 68.3%. A summary of findings was published on the NHIC web site on March 06, 2013. Based on this result, a widespread prepayment review was continued.

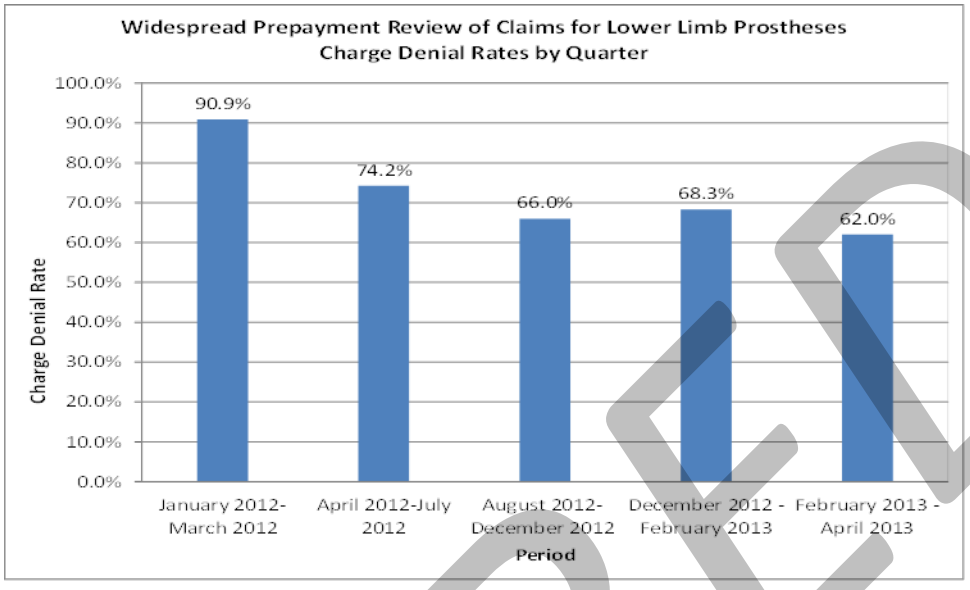
Current Review Results

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

The review involved prepayment complex medical review of 145 claims submitted by 105 suppliers for claims processed February 2013 to April 2013. Responses to the Additional Documentation Request (ADR) were not received for 30 (21%) of the claims. For the remaining 115 claims, 36 claims were allowed and 79 were denied resulting in a claim denial rate of 69%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 62%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Lack of Medical Record Documentation

- 27% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 8% of the denied claims were missing the evaluation/assessment documentation for the functional level of item(s) billed (prosthetist assessment).

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

- 31% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 15% of the denied claims were missing the proof of delivery. Delivery is missing Items delivered, manufacturer name and model number.

Claim Examples

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

Example 1:

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

Missing: Clinical documentation to support functional level of the device and to corroborate the prosthetist's records. Also missing was proof of delivery, which validates that the beneficiary received the items that were billed.

Example 2:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items dispensed, treating physician's signature and date, and the start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed; and the prosthetist's evaluation/assessment documentation detailing the functional levels of items billed.

Missing: The submitted clinical documentation did not support the functional level of the device and did not corroborate the prosthetist's records. Since the prosthetist is a supplier, the prosthetist's records must be corroborated by the information in the medical record.

Example 3:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; proof of delivery that includes the manufacturer, model numbers and cost of each item, which validates that the beneficiary received the items that were billed.

Missing: Clinician documentation to support functional level of device and to corroborate the prosthetist's records and the evaluation/assessment documentation for the functional level of item(s) billed.

Next Step

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

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

Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- The *DME MAC Jurisdiction A Supplier Manual* (Chapter 10: includes information regarding documentation requirements)
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/phy_letters.shtml
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses - Posted August 24, 2012; December 28, 2012; March 06, 2013
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Results of Widespread Prepayment Probe for Lower Limb Prostheses - Posted November 30, 2011
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Results of Widespread Prepayment Probe for Group 2 Pressure Reducing Support Surfaces (MOB)

Historical Review Results

This is the first DME MAC A Medical Review probe for Group 2 Pressure Reducing Support Surfaces, HCPCS E0277. This probe was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

Current Review Results

The DME MAC Jurisdiction A has completed the prepayment probe review of claims for Group 2 Pressure Reducing Support Surfaces, HCPCS E0277.

The review involved prepayment complex medical review of 102 claims submitted by 62 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 19 (19%) of the claims. For the remaining 83 claims, 32 claims were allowed and 51 were denied resulting in a claim denial rate of 61%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 59.2%.

Primary Reasons for Denial

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

Medical Documentation (53%)

- 6% of the denied claims did not include medical documentation.
- 37% of the denied claims did not meet one or more of the three coverage criteria:
    1. The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program.
    2. The beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or
    3. The beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

Detailed Written Order (45%)

- 20% of the denied claims did not include a detailed written order.
- 22% of the denied claims did not include a narrative description or a brand name/model number of the item being dispensed.
- 4% of the denied claims contained a detailed written order that was signed by the physician after the delivery date.

Proof of Delivery Issues (37%)

- 16% of the denied claims did not include proof of delivery.
- 4% of the denied claims contained proof of delivery that was not signed by the beneficiary.
- 10% of the denied claims contained proof of delivery that did not have a beneficiary signature date.
- 2% of the denied claims contained proof of delivery that did not list the item being delivered.

Claim Examples

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

Example 1:

Date of Service 8/21/12

Received: The supplier submitted a written order dated 8/23/12, which includes the beneficiary's name, detailed description of item, all options and accessories that will be billed separately or which require an upgraded code, signature of the treating physician and the date the order is signed and initial date of need or start date; Medical documentation from a hospital stay and cardiovascular procedures dated 8/13/12-8/24/12; Proof of delivery dated 8/24/12 which includes the beneficiary's name, delivery address, sufficiently detailed description to identify the item being delivered, quantity delivered, date delivered and beneficiary (or designee) signature and date of signature that validates that the beneficiary received the items that were billed.

Missing: The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.

Example 2:
Date of Service 9/28/12

Received: The supplier submitted a written order dated 9/21/12, which includes the beneficiary's name, all options and accessories that will be billed separately or which require an upgraded code, signature of the treating physician and the date the order is signed and initial date of need or start date; medical records consisting of a wound observation sheet dated 9/25/12 which stated the beneficiary has a stage II ulcer on the right buttock measuring 0.75cm circ, a second stage II ulcer on the right buttock measuring 0.75cm circ and a stage I ulcer on the sacrum measuring 3cmx3cm; and Proof of delivery dated 9/28/12 which includes the beneficiary's name, delivery address, sufficiently detailed description to identify the item being delivered, quantity delivered, date delivered and beneficiary (or designee) signature and date of signature that validates that the beneficiary received the items that were billed.

Missing: A detailed description of the item was missing on the written order. Also missing was documentation to support that the beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following: a) Use of an appropriate group 1 support surface, b) Regular assessment by a nurse, physician, or other licensed healthcare practitioner, c) Appropriate turning and positioning, d) Appropriate wound care, e) Appropriate management of moisture/incontinence, and f) Nutritional assessment and intervention consistent with the overall plan of care.

Example 3:
Date of Service 2/28/13

Received: The supplier submitted a written order dated 2/19/13, which includes the beneficiary's name, detailed description of item, all options and accessories that will be billed separately or which require an upgraded code, signature of the treating physician and the date the order is signed and initial date of need or start date; Medical documentation from a follow up appointment dated 3/11/13 as well as a letter of attestation dated undated stating that the beneficiary has pressure ulcers that are worsening; Proof of delivery dated 2/28/13 which includes the beneficiary's name, delivery address, sufficiently detailed description to identify the item being delivered, quantity delivered, date delivered and beneficiary (or designee) signature and date of signature that validates that the beneficiary received the items that were billed.

Missing: The beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program, the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis, or the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days ,and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. The submitted clinical documentation is also dated after the date of service.

Next Step

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

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

Educational References

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

- LCD for Pressure Reducing Support Surfaces - Group 2 (L5068)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- The *DME MAC Jurisdiction A Supplier Manual* "Welcome Page" provides valuable information to the CMS Web sites.
  Chapter 10: includes information regarding documentation requirements
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

- October 2012 CERT Errors
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (PEN)

Historical Review Results

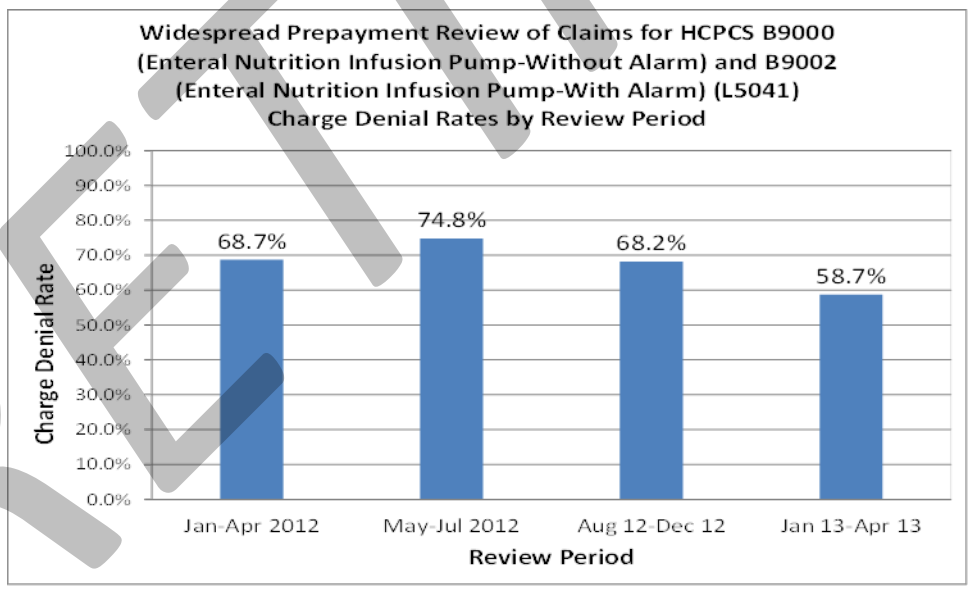
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed August 2012 thru December 2012 and resulted in a 68.2% Charge Denial Rate (CDR).

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 and B9002. These findings include claims processed primarily from January 01, 2013 through April 30, 2013.

The review involved prepayment complex medical review of 409 claims submitted by 80 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 126 of the claims. For the remaining 283 claims, 87 claims were allowed and 196 were denied/partially denied resulting in a claim denial rate of 66.1%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 58.7%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Clinical Documentation Issues

- 52.9% of the denied claims did not have any medical record documentation submitted.
- 13.1% of the denied claims had insufficient clinical documentation to justify the LCD criteria.
  a. a permanent non-function or disease of the structures that normally permit food to reach the small bowel

b. a disease of the small bowel which impairs digestion and absorption of an oral diet.

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

- 3.1% of the claims denied for statutory denial - does not meet prosthetic benefits requirement.

Proof of Delivery

- 9.5% of the denied claims had no Proof of Delivery
- 4.2% Incomplete delivery, no signature, no date of signature

Detailed Written Order Issues

- 9.5% of the denied claims had missing detailed written orders.
- 4.8% of the denied claims had incomplete detailed written orders.
  - Date of the detailed order was incomplete (missing month or year)
  - Physician's signature could not be authenticated

DME MAC Informational Form (DIF) Discrepancies

- 3.7% of the denied claims were missing a DIF

Claim Examples

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

Example 1:

Received: A detailed written order from the physician and a completed DIF, clinical notes and delivery ticket
Missing: Clinical documentation from physician demonstrating that the beneficiary is unable to swallow

Example 2:

Received: The supplier submitted a valid DIF, clinical notes, detailed physicians order, valid proof of delivery
Missing: Clinical documentation stated that beneficiary was able to take in oral nutrition without any swallowing difficulty. Enteral Nutrition is covered under the prosthetic benefit, therefore this is a statutory denial - does not meet benefit requirement

Example 3:

Received: DIF and Delivery ticket
Missing: Illegible physician's signature therefore unable to authenticate physician's signature on detailed clinical notes to support use of enteral pump. Missing signature log in documentation

Next Step

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

Educational References

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

- Enteral Nutrition (L5041) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (published 03/08/13, 07/20/012, 05/11/12, 12/22/12, 09/20/11, and 03/11/11)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Enteral Nutrition
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

- Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/self-service.shtml
- Frequently Asked Questions (search word Enteral)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Enteral Nutrition Supply Kits - Coverage Reminder
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_enteral-kits.pdf
- Monthly CERT Error examples
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (SPE)

Historical Review Results

DME MAC A Medical Review continues to review Nebulizers, with Compressor, based on the results of previous quarterly findings. The previous quarterly findings covered the period of September 2012 through January 30, 2013 and resulted in a Charge Denial Rate (CDR) of 58.9%

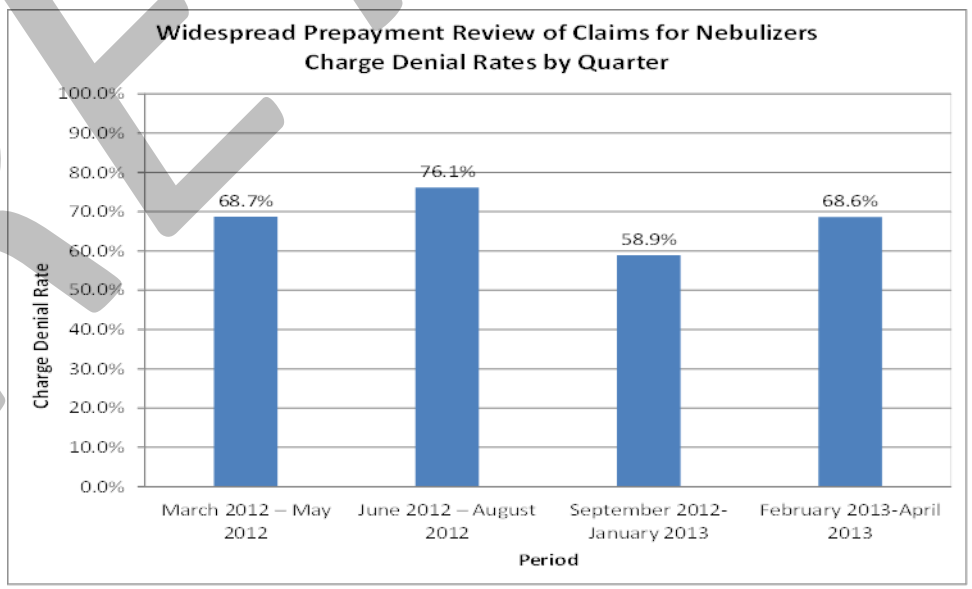
Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from February 2013 through April 30, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 1132 claims submitted by 511 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 299 (26%) of the claims. For the remaining 829 claims, 262 claims were allowed and 571 were denied/partially denied resulting in a claim denial rate of 69%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate (CDR) of 68.6%.

Charge Denial Rate Historical Data

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



Reasons for Denial

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

Clinical Documentation Issues

- 57% of the denied claims were missing any clinical information to support medical necessity.
  - No medical records were submitted
- 20% of the denied claims had insufficient clinical documentation. The following are specific issues identified with clinical documentation:
  - Clinical documentation did not support reasonable and necessary use of a nebulizer
    - Clinical documentation submitted did not list a payable diagnosis
    - Clinical documentation submitted had no mention of need for a nebulizer
  - Illegible copy of documentation submitted

Detailed Written Order Issues

- 3% of the denied claims were missing the detailed written order.
- 3% of the denied claims had an incomplete or invalid detailed written order. The following are specific issues identified:
  - Illegible copy of order
  - Start date or the date of physician signature was after the date of service and no dispensing order was submitted
  - Physician signature did not meet signature requirements; illegible Physician signature and unable to authenticate Physician signature with printed name and no signature log submitted.

Proof of Delivery Issues

- 7% of the denied claims were missing proof of delivery.
- 10% of the denied claims had an incomplete or invalid proof of delivery. The following are specific issues identified:
  - Illegible copy of proof of delivery
  - Nebulizer delivered to the beneficiary prior to the date of service of the claim
  - Missing sufficiently detailed description to identify the item(s) being delivered
  - Missing beneficiary signature and date of signature when item(s) are delivered directly by the supplier

Claim Examples

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

Example 1:

Received: Detailed order with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature; Clinical notes and proof of delivery.
Missing: Clinical notes do not explain reasonable and necessary use of a nebulizer. In instances where the nebulizer and supplies are delivered directly by the supplier, the date the beneficiary received the nebulizer device and supplies must be the date of service on the claim. The date of delivery for this claim was before the date of service.

Example 2:

Received: Detailed order with: beneficiary name, description of item to be dispensed, physician's legible signature, date of signature, proof of delivery to support the item ordered was received by the beneficiary
Missing: Order submitted was dated after the date of service and there was no dispensing order submitted. No clinical notes to support reasonable and necessary use of a nebulizer.

Example 3:

Received: Detailed order, proof of delivery with: beneficiary name and address, description of item to be delivered.
Missing: Illegible copy of order submitted. No clinical notes to support reasonable and necessary use of a nebulizer. No proof of delivery to support the item had been received by the beneficiary.

Next Step

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

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

Educational References

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

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective February 2011 (A24944)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Results of Widespread Prepayment Review of Claims for E0570

  (Posted 11/11/10, 03/25/11, 07/01/11, 12/22/11, 04/20/12, 08/17/12, 12/06/12, and 03/15/13)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Nebulizers
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Monthly CERT Error examples
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word "nebulizer")
  http://www.medicarenhic.com/faq_results.asp?categories=DME

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

Historical Review Results

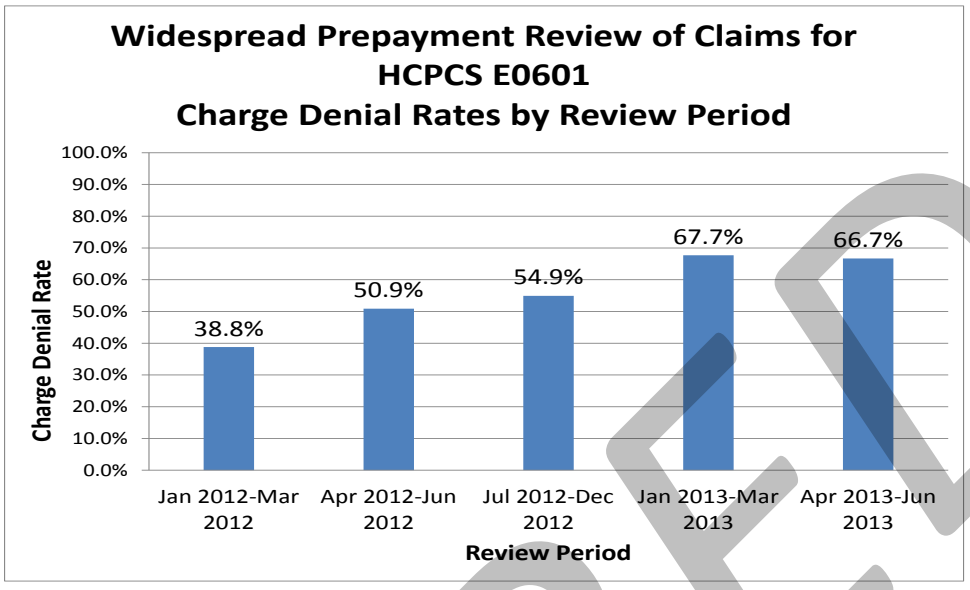
DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of the previous review findings. The previous quarterly findings covered claims reviewed from January 2013 through March 2013 and resulted in a 67.7% Charge Denial Rate (CDR).

Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from April 2013 through June 2013. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 952 claims submitted by 374 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 208 (22%) of the claims, of the 744 claims for which responses were received, 245 claims were allowed and 499 were denied/partially denied. This resulted in a claim denial rate of 67%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 66.7%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Face to Face Clinical Evaluation Documentation Issues

- 22.8% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
    - These claims had no Face-to-Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face-to-Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement following the 5 year Reasonable Useful Lifetime (RUL) or when requesting coverage of a replacement PAP upon entering FFS Medicare.
- 35.2% of the denied claims had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. The insufficient clinical documentation included:
    - Clinical documentation provided did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing presenting symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
    - Face-to-Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued benefit from sleep therapy.
    - Insufficient clinical documentation noted in Face-to-Face evaluations conducted by the treating physician in claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering Fee-for-Service (FFS) Medicare.
- 6.6% of the denied claims were missing the physician signature on the Face-to-Face clinical evaluation.
- 1.8% of the denied claims had illegible Face-to-Face documents.

Detailed Written Order Issues

- 3.2% of the denied claims did not include the Detailed Written Order.
- 11.2% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 0.8% of the denied claims had a Detailed Written Order which was illegible.
- 1.4% of the denied claims had Detailed Written Orders which were not dated.

Sleep Study Documentation Issues

- 7.8% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 0.8% of the denied claims had Sleep Study documents that did not meet coverage criteria per the PAP LCD.

- 13.6% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.
- 0.4% of the denied claims had Sleep Study documents which were illegible.

Training Documentation Issues

- 19.4% of the denied claims did not include evidence of training on the PAP device.
- 6.6% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face-to-face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 5.8% of the denied claims were missing Proof of Delivery.
- 13.8% of the denied claims had Proof of Delivery which was missing either the beneficiary's name, the beneficiary's delivery address, a sufficient description of the item(s) being delivered, quantity delivered, date delivered, billed items, or the beneficiary's signature and date of signature.
- 1.2% of the denied claims were delivered after the Date of Service.

Claim Examples

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

Example 1:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order, a Medicare approved Sleep Study, evidence of Training on the PAP device, and Proof of Delivery.
Missing: Medicare requires that services provided be authenticated by the treating practitioner. The Face-to-Face clinical evaluation did not contain a real or electronic signature by the treating practitioner.

Example 2:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written Order, and Medicare approved Sleep Study.
Missing: There is no evidence of training on the PAP device or Proof of Delivery.

Example 3:

Received: Included in this claim are a Face-to-Face clinical evaluation, a Detailed Written order, a Medicare approved Sleep Study, Proof of Delivery, and evidence of training on the PAP device.
Missing: The Proof of Delivery has been signed by the beneficiary after the Date of Service of the claim.

Next Step

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

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

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

Educational References

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

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601): Posted 05/31/2013, 02/28/2013, 11/30/2012, 08/24/2012, 04/20/2012, 12/22/2011, 08/19/2011, 03/04/2011, and 07/02/2010
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding general coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Positive Airway Pressure (PAP) Devices
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (MOB)

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from October 1, 2012 through December 31, 2012 and resulted in an 80.6% Charge Denial Rate (CDR).

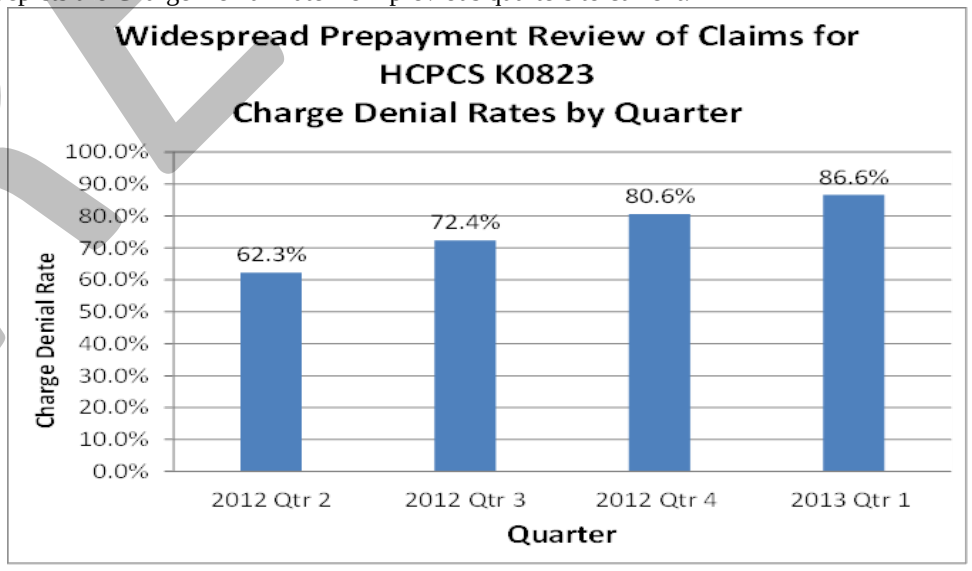
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings include claims with dates processed from January 1, 2013 through March 31, 2013. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 270 claims submitted by 133 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 42 (15%) of the ADR requests issued. Of the 228 claims for which responses were received, 25 of the claims were allowed and 203 of the claims were denied. This resulted in a claim denial rate of 89%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 86.6%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Face-to-Face Medical Documentation Issues

- 50% of the denied claims had insufficient clinical documentation to support medical necessity. Examples:
  - The Face-to-Face Clinical Evaluation documentation provided did not include a comprehensive physical exam by the treating physician which, focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ability. The Face-to-Face Clinical Evaluation did not provide a clear picture of the patient's specific mobility limitations (i.e., upper and lower body strength, range of motion, coordination, pain levels, physical deformities and physical endurance).
  - The Face-to-Face Clinical Evaluation documentation was completed by the treating physician using a supplier generated form which does not contain enough narrative information regarding the patient's specific mobility limitations to support the medical necessity for a power wheelchair.
  - The Face-to-Face Clinical Evaluation documentation provided did not clearly indicate that the reason for the visit was a mobility evaluation.
- 7% of the denied claims had a Face-to-Face date listed on the 7-Element Order that did not match the date of the Face-to-Face Clinical Evaluation.
- 6.5% of the denied claims did not have the treating physician's signature and/or the treating physician's signature date on the Face-to-Face Clinical Evaluation.
- 11% of the denied claims did not have the treating physician's signature in concurrence or disagreement with the LCMP examination.
- 10% of the denied claims did not have the treating physician's signature date on the LCMP examination.
- 7% of the denied claims did not include confirmation the supplier received a copy of the Face-to-Face Clinical Evaluation within 45 days of the completion of the Face-to-Face exam; as verified by a supplier date stamp or equivalent. A date stamp or equivalent was not present.

7-Element Order Issues

- 3% of the denied claims did not include a 7-Element Order.
- 16% of the denied claims were incomplete, missing one or more of the required elements.
- 10% of the denied claims did not include confirmation the supplier received a copy of the 7-Element Order within 45 days after the completion of the Face-to-Face Clinical Evaluation as verified by a supplier date stamp or equivalent. A date stamp or equivalent was not present.
- 4% of the denied claims have the 7-Element Order and the Detailed Product Description on the same form.
- 1% of the denied claims had an illegible 7-Element Order.

Detailed Product Description (DPD) Issues

- 8% of the denied claims did not include a Detailed Product Description.
- 11% of the denied claims had an incomplete Detailed Product Description.
- 3% of the denied claims had the Detailed Production Description dated prior to the physician's signature on the 7-Element Order.
- 7% of the denied claims did not include confirmation the supplier received a copy of Detailed Product Description prior to the delivery of the power wheelchair, as verified with a date stamp or equivalent from the supplier. A date stamp or equivalent was not present.
- 10% of the denied claims did not list a detailed description of the specific power wheelchair that the supplier had determine to be appropriate for the patient based on the physician's 7-Element Order.
- 3% of the denied claims did not have the treating physician's signature and/or the treating physician's signature date on the Detailed Product Description
- .5% of the denied claims had an illegible Detailed Product Description.
- Proof of Delivery Issues
- 5% of the denied claims did not include Proof of Delivery.
- 7% of the denied claims had Proof of Delivery that did not match the claim date of service.
- 5% of the denied claims did not include the beneficiary's signature and /or the beneficiary's signature date on the Proof of Delivery.
- 11% of the denied claims had items listed on the delivery ticket that did not match the items listed on the Detailed Product Description (DPD) and/or the ADS letter.

LCMP Specialty Exam issues

- 27% of the denied claims did not include a financial attestation statement stating the LCMP (Licensed/Certified Medical Professional) provider did not have a financial relationship with the supplier providing the wheelchair.

Home Assessment Issues

- 6% of the denied claims did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair, (PWC).
- 6% of the denied claims had home assessments that were not signed and dated by either the supplier or the practitioner.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

Example 1

Received: Documentation provided in this claim included: the 7-Element Order, the Face to Face Clinical Evaluation, the Detailed Product Description, the Home Assessment, and the Proof of Delivery.
Missing: The 7-Element Order did not include proof the supplier received a copy within 45 days, as documentation did not verify this by a supplier date stamp/equivalent. The Home Assessment did not include the signature of the supplier representative that performed the assessment.

Example 2

Received: Documentation provided in this claim included: the 7-Element Order, the Face to Face Clinical Evaluation, Specialty Evaluation, the Financial Attestation, the Detailed Product Description, the Home Assessment and the Proof of Delivery.
Missing: The Detailed Product Description did not include the ordering physician's signature and the ordering physician's signature date.

Example 3

Received: Documentation provided in this claim included: the 7-Element Order and the Face to Face Clinical Evaluation.
Missing: Documentation submitted with this claim did not include the Detailed Product Description, the Home Assessment and the Proof of Delivery.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS K0823.

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

Educational References

NHIC Corp. DME MAC and CMS provide extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Power Mobility Devices (L21271) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Power Mobility Devices - 7-Element Order (published 11/05/09)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf
- Face-to-Face Examination Date on 7-Element Order for Power Mobility Devices Scenarios (published 04/05/13)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/040513_f2f.pdf
- Power Mobility Devices Billing Reminder (published 01/11/08)
  http://www.medicarenhic.com/dme/articles/011108_pmd.pdf

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (published 3/28/13, 12/20/12, 9/28/12, 07/13/12, 04/20/12, 12/15/11, 08/26/11, 06/10/11, 03/11/11, and 11/05/10)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Frequently Asked Questions (search word PMD)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network; ICN 905063 September 2011)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf
- Power Mobility Device Face-to-Face Examination Checklist (SE1112)
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf

Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment, HCPCS E1390, E0431, and E0439 (OXY)

Historical Review Results

DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of October 01, 2012 through February 28, 2013 and resulted in a 41.1% Charge Denial Rate (CDR).

Current Review Results

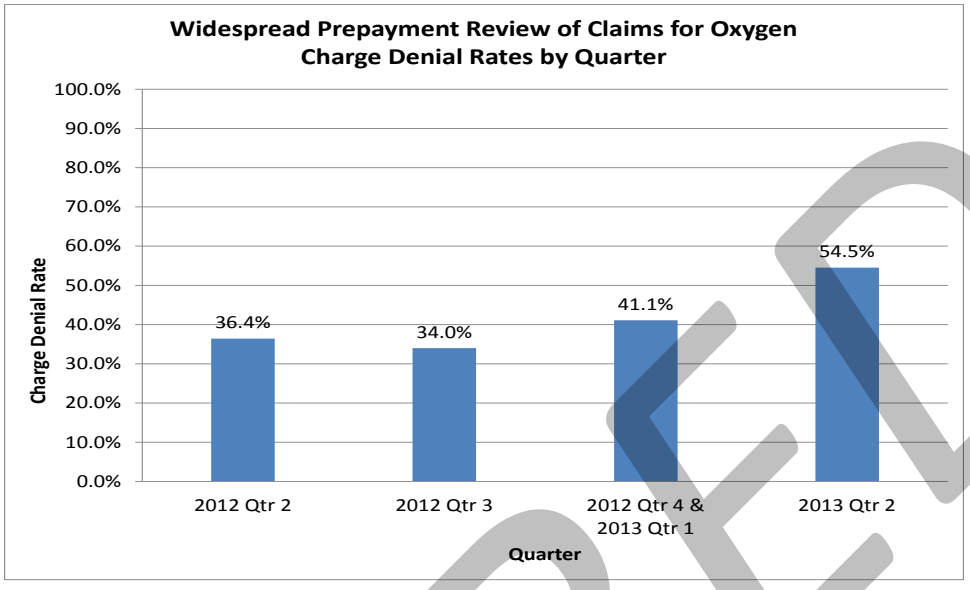
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from March 01, 2013 through May 31, 2013.

The review involved prepayment complex medical review of 591 claims submitted by 159 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 178 (30%) of the claims. For the remaining 413 claims, 214 claims were allowed and 199 were denied resulting in a claim denial rate of 48%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 54.5%.

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

Charge Denial Rate Historical Data

The following percentages depict the Charge Denial Rate from previous quarters to current:



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

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

1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and

2. The patient's blood gas study meets the criteria stated in the LCD, and

3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and

4. The qualifying blood gas study was obtained under the following conditions:
   a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
   b. If the qualifying blood gas study is not performed during an inpatient stay, the reported test must be performed while the patient is in a chronic stable state - i.e., not during a period of acute illness or an exacerbation of their underlying disease, and

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

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

Primary Reasons for Denial

Based on review of the documentation received, the following are the primary reasons for denial.

Missing Documentation (91%)

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

- 52% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN

Missing qualifying blood gas study per LCD L11468:

- 23% - No documentation to validate oxygen testing

Missing required Certificate of Medical Necessity per LCD L11468:

- 6% - Missing an Initial CMN or Initial CMN was incomplete

Missing valid proof of delivery per LCD L11468:

- 10% - Missing valid delivery ticket

Clinical Documentation Issues: Medical Necessity could not be established (9%):

Clinical documentation did not support criteria of LCD L11468 for the following reasons (3%):

- No indication in medical documentation of presence of severe lung disease or hypoxia related symptoms
- Medical documentation does not demonstrate that beneficiary was tested in a chronic stable state

Clinical documentation did not support criteria indicated on CMN for the following reasons (6%):

- Exercise testing did not qualify for Group I testing criteria, documentation did not demonstrate that exercise induced hypoxemia improves with use of oxygen therapy
- Blood gas study performed during sleep did not demonstrate that saturation was at or below 88% for at least 5 minutes
- Medical documentation received did not demonstrate qualifying oxygen saturation level. Written order only was received indicating an oxygen saturation level meeting Group I level criteria
- Saturation listed on CMN did not meet Group I criteria

Claim Examples

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

Example 1: DOS 11/16/12 Code Billed: E1390

Documentation received: written order dated 11/15/12, polysomnogram results dated 10/7/12, initial CMN dated 11/16/12, signed physician note dated 11/7/12, treatment authorization consent form, certificate of training, valid delivery ticket dated 11/16/12

Missing: Qualifying oximetry results in the medical documentation to validate the results provided in the initial CMN

Example 2: DOS 2/28/13 Code(s) Billed: E1390, E0431

Documentation received: Written physician order dated 2/20/13, initial CMN dated 2/28/13, documentation of physician visits dated 2/28/13 and 2/21/13, and a valid delivery ticket dated 2/28/13

Missing: Exercise oximetry report dated 2/28/13 including documentation of testing at rest without oxygen and testing during exercise with oxygen applied

Example 3: DOS 5/4/12 - 11/4/12 Code(s) Billed: E1390, E0431

Documentation received: Rental/sales agreement, written physician order dated 5/7/12, initial CMN dated 5/4/12, oximetry report dated 5/4/12 validating the blood gas study results provided on the initial CMN

Missing: Documentation of a physician visit dated within 30 days of the initial CMN, delivery ticket dated 5/4/12

Next Step

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

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

Educational References

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

Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD) (L11468) and related Policy Article (A33768) **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

- The *DME MAC Jurisdiction A Supplier Manual* "Welcome Page" provides valuable information to the CMS Web sites. Chapter 10: includes information regarding documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Error Articles - Monthly publications
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- CERT Physician Letter - Oxygen & Supplies
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word oxygen)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (Posted: 05/17/2013, 02/08/2013, 10/12/2012, 06/29/2012, 03/02/2012, 11/04/2011, 08/26/2011, 11/05/2010, and 06/09/2010).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- Results of Documentation Compliance Review (DCR) of Claims for Oxygen Equipment, HCPCS E1390
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/050313_e1390.pdf

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Widespread Documentation Compliance Prepayment Review for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (MOB)

NHIC, the DME MAC for Jurisdiction A, will be initiating a widespread prepayment Documentation Compliance Review (DCR) of claims for Power Mobility Devices Group 2 Power Wheelchair - K0823. This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) Contractor and through the Medical Review widespread prepayment review process for missing and/or incomplete documentation.

Suppliers will be sent an Additional Documentation Request (ADR) letter for the information listed below. The requested information must be returned within 45 days from the date of the letter to avoid claim denials.

The request will include the following:

1. The treating physician's 7-Element Order for a power mobility device
2. Documentation of a Face-to-Face encounter
3. A Home Assessment
4. A Detailed Product Description listing all items/options
5. Proof of Delivery Documentation

It is important for suppliers to be familiar with the documentation requirements as outlined in the LCD and Policy article. Suppliers can review the LCD on the NHIC DME MAC A Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

A common finding in these reviews is missing or incomplete records. To ensure compliance, please submit the requested information within the required timeframe.

ListServe Subscription - What is it and who should register? (GEN)

The DME MAC A ListServe subscriptions act as an electronic communication mechanism between the Jurisdiction A DME MAC contractor and our supplier community, which is used to notify subscribers of important and time sensitive Medicare program information. Only Internet access and a valid email address are necessary to join. Subscribers gain immediate access to the latest Medicare news, claim filing issues, policy changes as well as updates related to the following:

- Medicare publications (newsletters, articles, supplier manual updates, etc.)
- Educational training event offerings
- Urgent CMS announcements

Who should register?

In order to get the most out of these electronic mailing lists, the Jurisdiction A DME MAC recommends that all individuals who have a role in claim submission be registered. This includes all durable medical equipment, prosthetic, orthotic, and supply company owners, company compliance officers, office managers, billing staff, etc.

The following specialty/area of interest ListServes enable DME MAC A to send targeted information to specific supplier/provider audiences:

DME General Interest
Drug Coverage
Electronic Data Interchange (EDI)
Frequently Asked Questions (FAQs)
Medical Review/LCDs
Medicare Remit Easy Print (MREP)
Mobility/Support Surfaces
Oxygen
Parenteral/Enteral Nutrition (PEN)
Prosthetics & Orthotics
Specialty Items
Supplier Manual
Supplier Training & Event News
Vision

To register for the above ListServe topics visit:
http://visitor.constantcontact.com/email.jsp?m=1101306329206&p=oi

Second Quarter 2013 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2013, are provided in the following table.

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 - Rejected for relational field Information within the HCPCS	137,611	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.121.2010BA.NM109.020 - Invalid Information for a Subscriber's contract/member number	23,694	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.094.2010AA.REF02.050 - Billing Provider Tax Identification Number must be associated with the billing provider's NPI.	19,488	Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.087.2010AA.NM109.050 - Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	17,772	The NPI submitted is not linked to the Submitter ID under which the claim file was sent. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site and return to CEDI for processing.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.380.2400.DTP03.090 - Invalid Information within the Date(s) of service	12,867	The procedure code submitted for this line does not allow for spanned dates of service. Verify the "from" and "to" dates for this line are equal.
X222.226.2300.HI01-2.030 - Invalid Information within the Primary diagnosis code	12,283	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.380.2400.DTP03.080 - Invalid Information within the Future date and Date(s) of service	12,221	The service start/from date is greater than the date this claim was received.
X222.087.2010AA.NM109.030 - Invalid information in the Billing Provider's NPI	11,696	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.351.2400.SV101-3.020 - This Claim is rejected for relational field Information within the Procedure Code Modifier(s) for Service(s) Rendered	8,802	Procedure Modifier must be valid for the Service Date. (DTP01 = "472").
X222.351.2400.SV101-7.020 - This Claim is rejected for relational field Information within the Detailed description of service	7,259	Description must be present when Procedure Code requires a description/additional information.

Second Quarter 2013 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the second quarter of 2013. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from April through June 2013.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D -** Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	33,727
CO 182 N56 - Procedure modifier was invalid on the date of service	**Item 24d -** An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	12,218
OA109, N104 - This claim/service is not payable under our claims jurisdiction area.	The claim must be submitted to the correct Medicare contractor.	12,009
CO 16 N286 - Missing / incomplete / invalid referring provider primary identifier.	**Item 17A -** Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	2,733
CO 16 N64 - Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A -** Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,455
CO 16 MA114 - Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32 -** Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,824

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16 MA130 - Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11 -** If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	1,771
CO 16 M51 - Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D -** Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	1,534
CO 140 - Patient health identification number and name do not match.	**Item 1A -** This error is received when the patient's health identification number and name do not match.	1,320
CO 16 M51, N225, N29 - Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D -** Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	976

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

Supplier Manual News (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) *Supplier Manual* is available via the "Publications" section of our Web site at **http://www.medicarenhic.com/dme/dme_publications.shtml**. After accepting the CPT License Agreement, suppliers can access the entire *DME MAC A Supplier Manual*, including revised chapters and archived revisions. The *Supplier Manual* is available to current suppliers via the DME MAC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Updates/Corrections Made:

In June of 2013 chapters 5, 8, 9, and 12 of the *DME MAC A Supplier Manual* were updated, in July of 2013 chapters 3, 5, and 8 were updated, and in August 2013 chapters 1 and 8 were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

Quarterly Provider Update (GEN)

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

Updating Supplier Records (GEN)

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

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

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

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

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

DME MAC A ListServes (GEN)

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

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

Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at:
http://visitor.constantcontact.com/email.jsp?m=1101306329206&p=oi

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Quiz yourself and your staff. Visit the DME MAC A Test Your Knowledge Quizzes today at:
http://www.medicarenhic.com/dme/dme_quiz_index.shtml

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

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

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

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

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

For Your Notes

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

outreach-education@hp.com

Claims Submissions

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

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

Written Inquiries

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

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

Redetermination Requests Fax: 781-741-3118

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

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

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:
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Attention: ADMC
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Hingham, MA 02043-9170

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

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DME MAC Jurisdiction A Resource

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