The Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) processes durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims for beneficiaries who reside in the states of Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

The Jurisdiction B Connections is published quarterly in March, June, September, and December.

To receive up-to-date information about Medicare and/or changes within the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC), National Government Services, Inc. encourages suppliers to sign up for the electronic mailing list, Jurisdiction B DME MAC E-mail Updates.

**CMS Quarterly Provider Update**

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform providers and suppliers about the following:

- Regulations and major policies under development during the quarter
- Regulations and major policies completed or cancelled
- New or revised manual instructions

**Think Green and Go Paperless**

Suppliers should file claims electronically and you are encouraged to sign up for both the electronic remittance advice (ERA) and electronic funds transfer (EFT) to take advantage of the tremendous benefits associated with electronic transactions. Visit the Think Green and Go Paperless page on our Web site.
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APPEALS

Amount in Controversy Increases for 2014

Effective for Federal District Court requests filed on or after January 1, 2014, the amount in controversy increased to $1,430. The amount that must remain in controversy for review in Federal District Court requested before December 31, 2013 is $1,400.

The amount that must remain in controversy for Administrative Law Judge (ALJ) hearing requests filed before December 31, 2013 is $140. This amount will remain at $140 for ALJ hearing requests filed on or after January 1, 2014.

The amount in controversy is computed as the actual amount charged for the items and services in question, reduced by:

• Any Medicare payments already made or awarded for the items or services; and
• Any deductible and coinsurance amounts applicable in the particular case.

To meet the amount in controversy, suppliers may combine two or more claims to meet the amount in controversy requirements if:

• The claims were previously considered by the preceding level of appeal;
• The request for amount in controversy hearing lists all of the claims to be combined and is filed within the specified time frame; and
• The preceding level of appeals determines that the combined claims involve the delivery of similar or related services.

For additional information on appeals, suppliers may refer to Chapter 20 of the Jurisdiction B DME MAC Supplier Manual.

Notification of the Change in the Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge Hearing or Federal District Court Review

The purpose of this article is to publish notification of the change in the amount in controversy required to sustain appeal rights beginning January 1, 2014. Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an ALJ hearing or Federal District Court review. The amount in controversy is adjusted by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

The amount that must remain in controversy for ALJ hearing requests filed before December 31, 2013 is $140. This amount will remain at $140 for ALJ hearing requests filed on or after January 1, 2014. The amount that must remain in controversy for review in Federal District Court requested before December 31, 2013 is $1,400. This amount will increase to $1,430 for appeals to Federal District Court filed on or after January 1, 2014.
Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor Fourth Quarter 2013 Top Claim Submission Errors

The Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) conducted claim analysis for the fourth quarter of calendar year 2013 (October–December) of issues related to claim submission errors. Below is a chart listing the top claim submission errors as well as tips on how to reduce errors. The total denied claims for the fourth quarter was 672,231.
<table>
<thead>
<tr>
<th>ANSI Code</th>
<th>Category</th>
<th>Denial Type</th>
<th>October 2013</th>
<th>November 2013</th>
<th>December 2013</th>
<th>4th Quarter Total</th>
<th>% of Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO-16</td>
<td>Claim/service lacks information which is needed for adjudication.</td>
<td>Return/Reject</td>
<td>36,022</td>
<td>27,665</td>
<td>30,701</td>
<td>94,388</td>
<td>14.04%</td>
</tr>
<tr>
<td>CO-18</td>
<td>Duplicate Claim</td>
<td>Duplicate</td>
<td>22,212</td>
<td>16,728</td>
<td>26,920</td>
<td>65,860</td>
<td>9.80%</td>
</tr>
<tr>
<td>CO-151</td>
<td>Equipment is the same or similar to equipment already being used.</td>
<td>Same/Similar</td>
<td>13,730</td>
<td>8,088</td>
<td>9,923</td>
<td>31,741</td>
<td>4.72%</td>
</tr>
<tr>
<td>OA-24</td>
<td>Payment for charges adjusted. Charges covered under a capitation agreement/managed care plan.</td>
<td>Eligibility</td>
<td>10,895</td>
<td>4,902</td>
<td>5,017</td>
<td>20,814</td>
<td>3.10%</td>
</tr>
<tr>
<td>CO-176</td>
<td>Payment denied because the prescription is not current.</td>
<td>Return/Reject</td>
<td>6,569</td>
<td>5,376</td>
<td>5,950</td>
<td>17,895</td>
<td>2.66%</td>
</tr>
<tr>
<td>CO-4</td>
<td>The procedure code is inconsistent with the modifier used, or a required modifier is missing.</td>
<td>Return/Reject</td>
<td>6,389</td>
<td>5,372</td>
<td>6,040</td>
<td>17,801</td>
<td>2.65%</td>
</tr>
<tr>
<td>CO-173</td>
<td>Payment adjusted because this service was not prescribed by a physician.</td>
<td>Return/Reject</td>
<td>5,078</td>
<td>4,708</td>
<td>5,077</td>
<td>14,863</td>
<td>2.21%</td>
</tr>
<tr>
<td>CO-13</td>
<td>The date of death precedes the date of service.</td>
<td>Return/Reject</td>
<td>3,213</td>
<td>2,726</td>
<td>3,476</td>
<td>9,415</td>
<td>1.40%</td>
</tr>
<tr>
<td>OA-109</td>
<td>Claim is not covered by this payer or contractor.</td>
<td>Return/Reject</td>
<td>2,694</td>
<td>2,432</td>
<td>2,891</td>
<td>8,017</td>
<td>1.19%</td>
</tr>
<tr>
<td>CO-22</td>
<td>Payment adjusted because this care may be covered by another payer per coordination of benefits.</td>
<td>Eligibility</td>
<td>2,202</td>
<td>1,975</td>
<td>2,017</td>
<td>6,194</td>
<td>0.92%</td>
</tr>
</tbody>
</table>
1. CO-16 Claim/service lacks information which is needed for adjudication

Claims were submitted to the Jurisdiction B DME MAC that contained incomplete or invalid information and cannot be processed as submitted. Please refer to the remark code (REM) on the remittance advice (RA). The REM code advises what information is missing or incomplete on the claim. If the REM field is not complete, suppliers may contact the Provider Contact Center to request additional information regarding the ANSI-16 rejection. National Government Services has received an increase in the volume of claims submitted without a required modifier or with an invalid modifier. Suppliers are reminded to use the KX, GA, GZ, or GY modifier to indicate whether the coverage criteria are or are not met as outlined in the local medical policy. Since the KX modifier has a differing definition depending on the local coverage determination (LCD) requirements, suppliers should review the LCDs carefully to understand the proper use of the KX, GA, GZ, or GY modifiers for each policy. The LCDs and policy articles may be accessed through the National Government Services Web site, select the Medical Policy Center link located in the top navigation menu. Claims denied with ANSI-16 are not eligible for an appeal or a reopening. The rejected claim must be resubmitted with the missing/incomplete information.

2. CO-18 Duplicate claims

The Jurisdiction B DME MAC receives a large quantity of claims that result in duplicate denials. The duplicate claim submission denial is the number-one claims submission error. Generally, claim submission errors are services/items previously processed for the same patient, date of service, and Healthcare Common Procedure Coding System (HCPCS) code.

Suppliers are reminded to allow 14 days for electronically submitted claims and 29 days for hard copy claims before resubmitting a claim to the DME MAC. Suppliers should utilize the Claim Status Inquiry (CSI), NGSConnex, or the Interactive Voice Response (IVR) system at 877-299-7900 before resubmitting the claim for payment.

3. CO-151 Equipment is the same or similar to equipment already being used

Suppliers should evaluate the patient’s history during the intake process to determine if the same or similar equipment was previously obtained. Suppliers may utilize CSI, NGSConnex, or the IVR system at 877-299-7900 to determine if the beneficiary’s record indicates he/she already has the same/similar equipment. If the beneficiary wants the same/similar equipment and agrees to be financially liable, the supplier should have the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN) and submit the claim with modifier GA to indicate an ABN is on file. However, if a claim denies because the patient has previously received the same/similar equipment, and the supplier was unaware of the previous purchase, the supplier should refund the beneficiary (if applicable). The supplier may choose to exercise his/her right to request a redetermination. Redetermination requests should be submitted to the following address:

Redeterminations  
P.O. Box 6036  
Indianapolis, IN 46206-6036

Suppliers may also fax redetermination requests. Suppliers should complete the Medicare DME Redetermination Request Form and fax the redetermination request to 317-595-4737.

Suppliers also have the option to submit redetermination requests via a secure Internet portal NGSConnex. Access to NGSConnex only requires users to have the Internet and an e-mail address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.
4. OA-24 Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

The Jurisdiction B DME MAC records indicate that the beneficiary is enrolled in a Medicare Advantage plan, often referred to as a health maintenance organization (HMO). If the beneficiary elects to receive his or her Medicare benefits through a managed care plan, the beneficiary usually is required to receive all his or her care from doctors, hospitals, and other health care providers that are part of the plan. Beneficiaries enrolled in a Medicare HMO will receive an identification card from their Medicare HMO. Beneficiaries, doctors, hospitals, or any other health care provider must contact the HMO for details pertaining to coverage requirements. The DME MACs do not process claims for Medicare HMOs. Suppliers must submit their claim to the appropriate insurance carrier for the specific HMO in which the beneficiary is enrolled. The Jurisdiction B DME MAC encourages suppliers to utilize the Customer Care IVR system or CSI for assistance in determining whether the beneficiary is enrolled in a Medicare Advantage Plan/HMO.

By selecting Option 2 from the main menu of the IVR, suppliers will be able to obtain the Medicare HMO number, name, address, telephone number and effective/termination date of the plan. The IVR system is available from 7:00 a.m.–6:00 p.m. eastern time (ET), Monday through Friday, and 7:00 a.m.–3:00 p.m. most Saturdays. Suppliers may access the IVR system by dialing 877-299-7900. For additional information regarding the IVR system, suppliers should refer to the IVR guide located on the National Government Services Web site. Once on the DME home page, under the Resources menu on the top navigation, click Contact Us, and then select Interactive Voice Response System.

Online eligibility for all suppliers is also available through the CSI application. The CSI application and manual are available on the National Government Services Web site, select Claims, Electronic Submissions (EDI), and then select Enrollment Information/Forms.

5. CO-176 Payment denied because the prescription is not current

The Jurisdiction B DME MAC encourages suppliers to review the medical policies, referred to as local coverage determinations (LCDs), to verify whether or not an initial, revised, or recertification Certificate of Medical Necessity (CMN) is required for a specific item. When submitting claims that require a CMN, suppliers should ensure that all sections of the CMN are completed prior to submitting the claim to the DME MAC. Suppliers should submit the CMN with the initial claim only, and wait 24–48 hours before submitting any subsequent claims. The LCDs can be found in the Medical Policy Center on the National Government Services Web site.

However, if a claim denies because the patient has previously received same/similar equipment, and the supplier was unaware of the previous purchase, the supplier should refund the beneficiary or exercise his/her appeal rights and request a redetermination. Redetermination requests may be submitted to the following address:

Jurisdiction B DME MAC
Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

Suppliers may also fax redetermination requests. Suppliers should complete the Medicare DME Redetermination Form and fax the redetermination request to 317-595-4737.

Suppliers also have the option to submit redetermination requests via a secure Internet portal called NGSConnex. Access to NGSConnex only requires users to have the Internet and an e-mail address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.
6. CO-4: The procedure code is inconsistent with the modifier used, or a required modifier is missing

For a complete listing of the HCPCS Modifiers, please consult the Jurisdiction B DME MAC Supplier Manual, Chapter 14 “Level II HCPCS Codes and HCPCS Modifiers.” Additionally, specific instructions regarding modifier usage is located in the Jurisdiction B DME MAC Supplier Manual, Chapter 15, “DMEPOS Payment Categories.” The local coverage determinations and policy articles provide specific instructions for using the informational modifiers listed within the medical policy. Medical policies can be accessed from the Medical Policy Center section of the National Government Services Web site.

Suppliers may also utilize the DME Coding System (DMECS), to verify if the HCPCS code requires a primary pricing modifier. DMECS provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS items and CMS national fee schedules. To search for HCPCS and modifier coding or to find out more about the DME Coding System, please visit the Pricing, Data Analysis, and Coding Contractor’s Web site.

7. CO-173: Payment adjusted because this service was not prescribed by a physician

The Jurisdiction B DME MAC encourages suppliers to review medical policies to verify whether or not the items or services routinely provided to Medicare beneficiaries require an initial, revised or recertification CMN. When submitting claims that require a CMN, suppliers should ensure that all sections of the CMN are completed prior to claim submission to the DME MAC. Suppliers should submit the CMN with the initial claim only and wait 24-48 hours before submitting any subsequent claims. The medical policies are located within the Medical Policy Center on the National Government Services Web site.

8. CO-13: The date of death precedes the date of service

Medicare Part B coverage was not valid when the patient received this item and/or service. Expenses were incurred after coverage was terminated, prior to coverage, date of death precedes the date of service or Medicare was unable to identify the patient as an insured. Suppliers should contact the beneficiary to whom they are providing service, to determine whether the beneficiary is still using the supplier’s equipment. It is also recommended that suppliers check their patients’ Health Insurance Claim ard and Medicare records for valid coverage dates and for correct patient information prior to claim submission.

9. OA-109: Claim is not covered by this payer or contractor

This denial is given when the wrong payer or contractor has been billed. The most common reason for this denial is when the supplier submits a claim with an incorrect beneficiary address resulting in the claim being sent to the incorrect DME MAC. This ANSI is also received when the date of service on the supplier’s claim overlaps a beneficiary’s inpatient stay in a hospital or a skilled nursing facility. Verify the beneficiary’s eligibility via NGScConnex or the IVR system. Once eligibility has been verified, resubmit the claim to the appropriate payer or contractor. In cases where the inpatient dates are incorrect, the supplier is encouraged to work with the beneficiary, the caregiver, and/or the facility to get the date of discharge correct. Once the discharge dates have been corrected, the supplier may resubmit their claim to the DME MAC for payment. Prior to resubmission, NGScConnex and/or the IVR should be checked again to confirm the correction has been made to the discharge dates.
10. CO-22: Payment adjusted because this care may be covered by another payer per coordination of benefits

The Jurisdiction B DME MAC records indicate that Medicare is the secondary payer. When Medicare is the secondary payer, suppliers must send the claim to the primary payer first and then submit the claim to Medicare with a copy of the primary payer’s explanation of benefits (EOB) notice. When claims are submitted to Medicare as primary and another insurer is actually the primary payer, claims will be denied with the following explanation: “Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first. Resubmit this claim with a copy of the primary payment notice.” Suppliers must send these claims to the correct payer/contractor and then resubmit the claim to Medicare with a copy of the primary payment notice or the EOB. If the beneficiary’s Medicare Secondary Payer records are outdated, suppliers should advise the beneficiary to contact the Coordination of Benefits Contractor at 800-999-1118 to have their MSP control file updated.

Are You Ready for ICD-10?

ICD-10 code sets will replace ICD-9 codes sets effective October 1, 2014. The Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) recently added an ICD-10 page to our Web site to assist you in understanding the new code sets and to provide valuable resources to ensure you are compliant by the deadline. Visit our ICD-10 Web page on the National Government Services Web site by visiting the Tools and Materials section under Resources. Click on ICD-10 Implementation which is located under the Claim Completion Tips section.

Repairing or Providing Supplies, Accessories, and Drugs Used with Beneficiary-Owned Equipment

Medicare will consider coverage for supplies, accessories, and drugs used with beneficiary-owned equipment. Medicare will also consider coverage of repairs to beneficiary-owned equipment not covered by supplier or manufacturer warranty. The beneficiary-owned equipment must:

1. Be eligible for a defined Medicare benefit category,
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
3. Meet all other applicable Medicare documentation, coverage, statutory and regulatory requirements.

In the event of an additional documentation request from any Medicare contractor or upon submission of an appeal request, suppliers should provide information justifying the medical necessity for the base item that is need of repair or requires the supplies, accessories, or drugs.

Suppliers should refer to the applicable local coverage determination(s) and related policy article(s) for information on the relevant coverage, documentation, and coding requirements.

Ordering/Referring Physician Checklist for Durable Medical Equipment, Prosthetic, Orthotic, and Supplies Suppliers

Effective January 6, 2014, the CMS turned on the Phase 2 ordering/referring denial edits. This means that Medicare will deny DMEPOS claims if the ordering/referring physician is not identified, not enrolled in PECOS, or not of a specialty type that may order/refer the service/item being billed.
Phase 1 – Claims with dates of service prior to January 6, 2014

Claims with dates of service prior to January 6, 2014 billing providers/suppliers will continue to receive informational messages on their remittance advices to alert them that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer.

- N544 – Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.

Phase 2 – Claims with dates of service on or after January 6, 2014

A claim submitted with a date of service on or after January 6, 2014 will be denied with one of the following ANSI denials if the ordering/referring provider NPIs reported on the claim does not pass the edits.

Only physicians and certain types of nonphysician practitioners are eligible to order or refer items or services for Medicare beneficiaries. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied.

- Chiropractors are not eligible to order and refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Optometrists may only order and refer DMEPOS items, laboratory and x-ray services.

Example: A DMEPOS claim is submitted and the ordering/referring physician name and NPI listed on the claim are for a chiropractor, the claim will be denied because a chiropractor is not eligible to order and refer DMEPOS items for Medicare beneficiaries.

If the referring/ordering provider name reported on the claim does not match what is stored in PECOS the claim will be denied with the following ANSI denial and Remark codes:

- CO-16 – Claim/service lacks information which is needed for adjudication
  - N264 – Missing/incomplete/invalid ordering provider name.
  - N575 – Mismatch between the submitted ordering/referring provider name and records

Example: A DMEPOS claim is submitted and the ordering/referring physician’s last name entered on the claim does not match what is in PECOS (i.e., name spelled incorrectly, wrong name entered, etc.). This would cause the claim to fail the Phase 2 edits and the claim would be denied.

If the referring/ordering provider NPI reported on the claim is missing or does not match a provider record in PECOS the claim will be denied with the following ANSI denial and Remark codes:

- CO-16 – Claim/service lacks information which is needed for adjudication
  - N265 – Missing/incomplete/invalid ordering provider name.
  - N276 – Mismatch between the submitted ordering/referring provider name and records

Example: A DMEPOS claim is submitted and the ordering/referring physician’s NPI listed on the claim does not match what is in PECOS (i.e., number transposed, wrong number entered, etc.). This would cause the claim to fail the Phase 2 edits and the claim would be denied.

Statutorily Noncovered Items – GY Modifier

Medicare will not pay for services excluded by statute, which often are services not recognized as part of a covered Medicare benefit. If a claim is submitted using the GY modifier and the claim is missing an ordering and referring provider or the provider is not authorized to order and refer, the claim will be denied with the following ANSI denial codes:
• PR-96 – Noncovered charges
• PR-204 – This service/equipment/drug is not covered under the patient’s current benefit plan

Steps to Prevent Unnecessary Denials

1. Check the “Ordering Referring Report” – This file contains the NPI and names of physicians and nonphysician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. CMS updates the report on a periodic basis, and each document includes a create date. This file is available on the CMS Web site.

2. If the physician or nonphysician practitioner appears on the file, follow these tips for claim submission to avoid denials for invalid format of ordering physician and nonphysician practitioner names:

   a. **File a new claim – no need to file an appeal if you received a claim denial with one of the above CARC and RARC messages.**

      i. Ensure you are correctly spelling the ordering/referring provider’s name. Use the name and NPI exactly as it appears on the “Ordering Referring Report” which comes directly from PECOS. The edits will compare the first four letters of the last name.

      ii. Do not use “nicknames” on the claim, as their use could cause the claim to fail the edits.

      iii. Do not enter a credential (e.g., “Dr.”) in a name field.

      iv. Special characters, such as apostrophes (’) or hyphens (–), appear in some names on the PECOS list and should be submitted on the claim as such. Spaces must also be present as depicted on the CMS PECOS list.

      v. Make sure the last name is in the last name field and first name in the first name field.

      1. On paper claims (CMS-1500), enter the ordering provider’s first name first, and last name second (e.g., John Smith), in Item 17.

      2. On electronic claims, ensure that you are not submitting the last name in the first name field and vice versa.

      vi. Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or nonphysician practitioner and not to an organization, such as a group practice that employs the physician or nonphysician practitioner who generated the order or referral.

      vii. Make sure that the qualifier in the electronic claim 2420E NM102 loop is a one (person). Organizations (qualifier two) cannot order and refer.

3. If the physician does not appear on CMS’ “Ordering Referring Report,” contact the ordering/referring physician to find out if they are in the process of enrolling with Medicare. The CMS “Ordering Referring Report” will include a create date; any applications processed after the create date will not appear on the report until it is next updated. Services ordered by a physician who is not enrolled in Medicare will be denied. Check the “Ordering Referring Report” weekly for newly enrolled providers.

Reminders

Billing providers should be aware that claims that are denied because they failed the ordering/referring provider edits would not expose the Medicare beneficiary to liability. Therefore, an ABN is not appropriate.

**Chiropractors** are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.

**Opt-Out Physicians and Nonphysician Practitioners:** A physician who has opted out of Medicare may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare
contractor within the physician’s specific jurisdiction. Opt-out physicians who are able to order or refer Medicare services will appear on the “Ordering Referring Report.”

DVA, PHS, or the DOD/Tricare: These physicians and nonphysician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. DVA, PHS or DoD/Tricare physicians who are able to order or refer Medicare services will appear on the “Ordering Referring Report.”


Changes to Your Remittance Advices

Effective for claims with dates of services on or after January 1, 2014, you may notice a change in the combination of claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) you see on your remittance advice. It is imperative for you and your staff to carefully review your remittance advices in order to determine if a change has occurred, to identify the new denial code, and to determine who will be liable if the services were not covered by Medicare.

The following CARCs will be changing from a group code of OA to group code CO:

- 24 – Charges are covered under a capitation agreement/managed care plan.
- 109 – Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
- B11 – The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- 163 – Attachment/other documentation referenced on the claim was not received.
- 164 – Attachment/other documentation referenced on the claim was not received in a timely fashion.
- 165 – Referral absent or exceeded

CARC code 18 (exact duplicate claim/service) was recently changed from group code CO to group code OA.

Additional changes will be occurring with the CARCs and RARCs based upon MLN Matters articles 8518 and 8365. These MLN Matters articles MM8518 and MM8365 are posted to the News Articles section of the NGSMedicare.com Web site.

In the near future, Jurisdiction B resources will be updated in order to reflect the new CARCs and RARCs combinations.

Revised: Billing a Not Otherwise Classified Health Care Common Procedure Coding System Code

Effective immediately any Healthcare Common Procedure Coding System (HCPCS) code with a narrative description that indicates “NOC,” unlisted, or nonspecified that is billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) must include the following additional information to allow proper adjudication.

Common Electronic Data Interchange Edits

Any HCPCS code with a narrative description that indicates not otherwise classified (NOC), unlisted, or nonspecified that is billed to the DME MAC electronically must include in the SV101-7 segment for Health
Insurance Portability and Accountability Act (HIPAA) 5010A1 claims, a concise description of the NOC code. This segment is limited to 80 characters. If the claim is submitted without this information it will not pass the front-end edits and will be rejected by Common Electronic Data Interchange (CEDI) with:

- Claim status category coed (CSCC) A8: “Acknowledgement/Rejected for relational field in error”
- Claim status code (CSC) 306: Detailed description of service
- Edit Reference: X222.351.2400.SV101-7.020

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

In addition, any HCPCS code with a narrative description that indicates NOC, unlisted, or nonspecified, that is billed to the DME MAC must also include the following in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the American National Standards Institute (ANSI) X12N, version 5010A1 professional electronic claim format or in Item 19 of the paper claim form:

- Concise description of the item billed
- Manufacturer’s name
- Product name/product number (if applicable)
- Model number/serial number (if applicable)
- Acronym “MSRP” or “MSP”
- Manufacturer’s suggested retail price (MSRP)

**Note:** In rare cases MSRP information is not available; in those rare cases suppliers should indicate “NO MSRP.”

There is a limit of 80 character spaces in the line note, so suppliers should abbreviate when possible. View the suggested abbreviations list on the National Government Services Web site.

Claims submitted to the DME MAC without the additional information required for adjudication will be rejected with ANSI code CO-16 with a reason code N350 which states, “Missing, incomplete, invalid description of service for an NOC code or an Unlisted procedure.” Appeal rights are not afforded and in order to correct these claim rejections suppliers must correct the claim and provide all of the required additional information needed for adjudication and resubmit.

Additional information regarding situations requiring a narrative explanation in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or Item 19 of the claim form can be found in article titled “Situations Requiring a Narrative Explanation in Item 19,” available on the National Government Services Web site.

**DOCUMENTATION**

**Proof of Delivery Errors**

National Government Services has been conducting audits on various policies. Many denials occur from incorrect or missing proof of delivery. This is unnecessary since this documentation is controlled by the supplier. The following are some of the errors noted during these audits:

**Parenteral and Enteral Nutrition**

Proof of delivery documentation must support and provide information regarding what was actually delivered at that time. The date of service on the claim should match the delivery or shipping date on the proof of delivery documentation. The items provided should also match the units of service billed. If delivering on a weekly basis, the proof of delivery documentation and claim should match this delivery date. National Government Services has found suppliers are delivering on a weekly basis but billing on a
monthly basis. This is incorrect billing and the proof of delivery documentation does not match the claim. Suppliers should ensure they are billing according to their delivery/shipping procedure.

**Pharmacy and Retail Store Pickup**

When a beneficiary picks up an item from a retail store or pharmacy, the delivery address should be the address where the beneficiary received the item. This address can be anywhere on the proof of delivery documentation. Adding the beneficiary’s address to the proof of delivery documentation does not make the documentation invalid. If the beneficiary signs a log, there must be a way to link this log to an internal invoice providing information regarding what items or supplies were actually provided at that time. The documentation is deemed invalid if the signature log is only linked to the order. The order is a separate piece of required documentation and indicates what is ordered, not what is provided.

**Method 3 or Delivery to Skilled Nursing Facilities**

When delivering to beneficiaries residing in a skilled nursing facility, the proof of delivery documentation must specify what each beneficiary received. The documentation must not provide documentation indicating a bulk delivery. A reviewer must be able to clearly tell what each beneficiary received on the specified date and this documentation must coincide with the billing.

It is important for suppliers to ensure that the proof of delivery documentation provided with an additional documentation request (ADR) clearly indicates the items delivered, the quantity billed, and the ship/delivery date matches the date of service on the claim. Suppliers are encouraged to review their supplier manual for more information regarding proof of delivery.

**Clarification of Face-to-Face Encounter Requirements for Certain Durable Medical Equipment**

On December 3, 2013, the Centers for Medicare & Medicaid Services (CMS) published an announcement regarding the delay in enforcement of the face-to-face requirements established by Section 6407 of the Affordable Care Act. This announcement clarified that the enforcement delay only applies to the new durable medical equipment (DME), face-to-face requirements. While active enforcement of the face-to-face requirements has been postponed until a future date to be announced in calendar year 2014, the delay does not impact provisions related to written orders prior to delivery. National Government Services will begin enforcement of the written order prior to delivery requirement for date of service (DOS) on or after January 1, 2014.

Accordingly, as of July 1, 2013, the DME items on the Specified Covered Items list require that the supplier obtain a detailed written order prior to delivery. All written orders shall follow the guidance in the CMS Internet-Only Manual (IOM) Publication 100/08, *Medicare Program Integrity Manual*, Chapter 5, Section 5.2.3, and shall include, at a minimum, the following elements listed in the regulation:

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

The requirements listed in the regulation do not supersede other CMS requirements for detailed written orders. Per the standard documentation guidelines, detailed written orders must also include the following:

1. physician’s name
2. start date of the order (if different from the date of the order)
3. signature date personally entered by the ordering practitioner
4. dosage or concentration, if applicable
5. route of administration, if applicable
6. frequency of use
7. duration of infusion, if applicable
8. quantity to be dispensed, and
9. number of refills, if applicable

Failure to obtain a valid detailed written order prior to delivery will result in the item being denied as excluded by statute.

For additional information concerning the face-to-face encounter requirements and a list of DME items on the specified covered list, please refer to the CMS MLN article, “MM8304 Revised – Detailed Written Orders and Face-to-Face Encounters.”

**Face-to-Face and Written Order Requirements for High Cost DME Dear Physician Letter Now Available**

For certain specified items of durable medical equipment (DME) the Affordable Care Act requires that an in-person, face-to-face examination (F2F) documenting the need for the item must have occurred sometime during the six months prior to the order for and delivery of the item. The purpose of the DME dear physician letter is to provide a summary of these requirements.

To view the letter titled “Dear Physician Letter: Face-to-Face and Written Order Requirements for High Cost DME,” go to the Policy Education page of the National Government Services Web site.

**New Cost-Saving NGSConnex Enhancement: Responding to Additional Documentation Requests**

National Government Services is pleased to announce our most recent NGSConnex enhancement: Responding to additional documentation requests (ADRs). This new feature allows durable medical equipment (DME) suppliers the ability to respond to a Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) ADR online. With just a few clicks you can upload the requested documentation and submit the documentation through the free NGSConnex Web portal thus saving time and money associated with printing and mailing documentation.

Not only will you be able to submit the documentation via NGSConnex, but NGSConnex also allows you to view the history of these submissions and the attachments included with the requests.

This new feature is available now, so you can begin saving money immediately by responding to additional documentation requests via NGSConnex!

You will find step-by-step instructions on how to submit and view ADR documentation within the Quick Steps Job Aid posted on the home page of NGSConnex, under the Links section.

**Sign up to Save Time and Money**

If you are not currently using NGSConnex, sign up today so that you too can begin saving time and money associated with printing and mailing requested documentation. To sign up for NGSConnex, follow the setup instructions on the National Government Services Web site, under the Resource section, select NGSConnex or use the Quick Steps Job Aid located on the home page of NGSConnex, under the Links section.
If you have any questions on the setup process or need assistance with NGSConnex, you can contact the Provider Contact Center at 866-590-6727.

**FEE SCHEDULE, PRICING, AND OVERPAYMENTS**

**Notice of New Interest Rates for Medicare Overpayments and Underpayments — Change Request 8624**

The interest rates on overpayments and underpayments is determined in accordance with regulations promulgated by the Secretary of the Treasury and is the higher of the private consumer rate or the current value of funds rate prevailing on the date of final determination. Interest accrues from the date of the initial request for refund and is assessed for each 30-day period, or portion thereof, that payment is delayed after the initial refund request.

Interest assessed for both late payments and installment payments is computed as simple interest using a 360-day year. Simple interest is interest that is paid on the original principal balance and after each payment interest accrues on the remaining unpaid principal balance. Interest charges will not be prorated on a daily basis for overdue payments received during the month (e.g., 10, 15, or 20 days late). Interest is assessed for the full 30-day period. The interest rate on each of the final determinations will be the rate in effect on the date the determination is made.

If periodic but unscheduled payments or credits are made in different calendar quarters, the quarterly rate prevailing at the time of the final determination is charged and remains the same until the debt is liquidated. Interest must be recalculated based on the outstanding balance at 30-day intervals from the date of final determination.

The interest rate charged on overpayments repaid through an approved extended repayment schedule is the rate that is in effect for the quarter in which the determination was made. The rate remains constant unless the provider defaults (i.e., misses two consecutive installment payments) on an extended repayment agreement. When the provider defaults on such an agreement, interest on the balance of the debt may be changed to the prevailing rate in effect on the date of the default if that rate is higher than the rate specified in the agreement.

<table>
<thead>
<tr>
<th>Period Rate</th>
<th>Interest</th>
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<tr>
<td>October 18, 2012 - January 16, 2013</td>
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</tr>
<tr>
<td>January 17, 2013 - April 16, 2013</td>
<td>10.625%</td>
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<tr>
<td>April 17, 2013 - July 16, 2013</td>
<td>10.125%</td>
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<td>July 17, 2013 - October 17, 2013</td>
<td>10.375%</td>
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<td>October 18, 2013 - January 20, 2014</td>
<td>10.125%</td>
</tr>
<tr>
<td>January 21, 2014</td>
<td>10.25%</td>
</tr>
</tbody>
</table>

**Medicare’s Acceptance of Voluntary Refunds**

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.
MEDICAL POLICY

Local Coverage Determination and Policy Article Revisions
Summary for November 15, 2013

Outlined below are the principal changes to Durable Medical Equipment Medicare Administrative Contractor (DME MAC) local coverage determinations (LCDs) and policy articles (PAs) that have been revised and posted. Please review the entire LCD and related PA for complete information.

Nebulizers

**LCD**
Revision Effective Date: 08/02/2011 (November 2013 Publication)
HCPCS CODES AND MODIFIERS:
Added: HCPCS code A7018

**PA**
Revision Effective Date: 04/01/2013 (November 2013 Publication)
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
Revised: Refill Information

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

Policy Article Revision Summary for November 27, 2013

Outlined below are the principal changes to Durable Medical Equipment Medicare Administrative Contractor (DME MAC) local coverage determinations (LCDs) and policy articles (PAs) that have been revised and posted. Please review the entire LCD and related PA for complete information.

Glucose Monitor

**Policy Article**
Revision Effective Date: 01/01/2014
CODING GUIDELINES:
Revised: Billing of testing supplies dispensed with initial issue of glucose monitor
Revised: Bundling table

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

Local Coverage Determination Revision Summary for December 19, 2013

Outlined below are the principal changes to Durable Medical Equipment Medicare Administrative Contractor (DME MAC) local coverage determinations (LCDs) and policy articles (PAs) that have been revised and posted. Please review the entire LCD and related PA for complete information.
Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea

**LCD**

Revision Effective Date: 01/01/2014

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Titration PSG language and qualifying patients for oxygen therapy

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

**Policy Article Revision Summary for January 30, 2014**

Outlined below are the principal changes to a Durable Medical Equipment Medicare Administrative Contractor (DME MAC) policy article (PA) that has been revised and posted. Please review the entire local coverage determination (LCD) and related PA for complete information.

**Tracheostomy Care Supplies**

**Policy Article**

Revision Effective Date: 03/01/2014

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES and CODING GUIDELINES:
Added: AU modifier usage for A5120 (wipes or swabs) in the same manner as is used for A4450 & A4452

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

**MEDICARE SECONDARY PAYER**

**MSP Refund Check and Refund Correspondence P.O. Box Discontinued**

Effective February 28, 2014, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) will discontinue use of our MSP refund check and refund correspondence P.O. Box. As of February 28, MSP related refund checks and refund correspondence should be submitted to:

National Government Services, Inc.
17003 DME MAC
P.O. Box 809305
Chicago, IL 60680-9273

Please keep in mind that this change is only for Medicare Secondary Payer (MSP) refund checks and refund correspondence. All other MSP correspondence will continue to go to P.O. Box 6036 in Indianapolis, Indiana.

Please view the **P.O. Box Mailing Addresses Web page** on the National Government Services Web site for a complete listing of addresses.
The Medicare Hospice Benefit: Effects on Other Provider Types

Hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual’s life expectancy is 6 months or less if the illness runs its normal course.

To view this article in its entirety, go to the Tools and Materials section of the Resources page on the National Government Services Web site.

NGSConnex Offers Many Time-Saving and Cost-Saving Features

NGSConnex is an online Web application developed by National Government Services that allows you secure access to a wide array of Medicare tools and information at your fingertips. NGSConnex offers you superior search capabilities that make it fast and easy for you to find the information you need without having to place calls to the National Government Services Provider Contact Center or interactive voice response (IVR) system. National Government Services wants to make NGSConnex your “go to” tool for fast and easy access to information and for performing routine business functions. For this reason, we are continually developing new cost-saving and time-saving features. Take a look at the many features NGSConnex currently has to offer.

- Check beneficiary eligibility and entitlement information
- Print beneficiary eligibility and entitlement information—NEW
- Check status of claims
- View your provider/supplier demographic information
- View financial data for your supplier
- View same and similar and Certificate of Medical Necessity (CMN) detail
- Submit reopening and/or redetermination requests
- Obtain the status of all redetermination/reopening requests
- Obtain offset information
- Submit an inquiry and view response
- Initiate power mobility device prior authorization requests (PMD PAR) and view history of requests
- Submit advanced determination of Medicare coverage (ADMC) requests and view history or requests
- Respond to additional documentation requests (ADR) and view history of ADR documentation submitted via NGSConnex—NEW
- There is no cost for access to NGSConnex and it only requires users to have an e-mail address and Internet access. There are also no limits to the number of users within NGSConnex for each company.

To get started go to the NGSConnex Web site. Use the Quick Steps Job Aid to learn how to create a user account. The Quick Steps Job Aid is available from the NGS Connex Home page. You’ll see the Quick Steps Job Aid within the Links box to the right of the User Login. The Quick Steps Job Aid provides step-by-step instructions for every feature within the NGSConnex application, from creating an account to responding to an ADR—our newest feature.

If you have not yet signed up for NGSConnex, what are you waiting for?
New NGSConnex Features Now Available

National Government Services strives to continue to enhance our Web portal, NGSConnex to meet the needs of the supplier community. We are excited to announce that we have added the following two new fields to the claims view screen.

- Co-insurance Amount
- Deductible Amount

Coming Soon

You will be able to view and print remittance information at the claim line level. Look for more information about this new feature in the near future.

Not Registered for NGSConnex?

NGSConnex is a secure portal that offers many features to help you with your Medicare billing process. You can view claim status, check eligibility, check same/similar information, submit redetermination requests, and much more. If you need assistance with signing up or using NGSConnex, go to http://www.NGSConnex.com and select the "Quick Steps Job Aid" link located at the top of the NGSConnex homepage.

Revised: Enhancements Coming Soon to the Same/Similar Functionality in NGSConnex!

Supplier\\s who provide prosthetics, orthotics, and supplies will soon be able to utilize NGSConnex to look up same/similar information on these items!

Currently, suppliers may contact the Provider Contact Center to verify if the Jurisdiction B DME MAC has processed prosthetics, orthotics, and supplies on a preclaim basis. NGSConnex will soon be enhanced to provide the same/similar information on a preclaim basis for prosthetics, orthotics, and supplies.

Additional information will be communicated once this enhancement is available.

Suppliers who currently do not use NGSConnex are strongly encouraged to sign up for this free Web-based application. By using NGSConnex to obtain same/similar information suppliers will save time by having this information at their fingertips on prosthetics, orthotics, and supplies.

To create a user account for NGSConnex:

1. Access the Connex online Web application.
2. Read the standard disclaimer and click the I Agree button to continue.
3. Click the New User link on the log in screen.
Additional instructions are available in the NGSConnex Quick Steps Job Aid.

**Related Content**
- NGSConnex
- NGSConnex Quick Step Job Aid

**Provider Contact Center Reminders**

The National Government Services, Jurisdiction B DME MAC Provider Contact Center (PCC) is a valuable resource available to our durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) customers. Customer Care Representatives (CCRs) are available to assist you with a wide-range of Medicare coverage and billing-related inquiries. CCRs strive each day to assist as many customers as possible with accurate information. You can assist in this effort by asking the CCR very clear concise questions and by being prepared to provide all necessary information needed by the CCR to answer your questions. Our PCC number is 866-590-6727.

If you contact the PCC with an inquiry that can be addressed via the interactive voice response (IVR) system, you will be advised to disconnect and call the IVR for the information. The IVR toll-free number is 877-299-7900.

Below are tips to maximize your experience when contacting the PCC.

**Initially Suppliers Must Have the Following Information Available**
- National Provider Identifier (NPI)—the NPI number linked to your PTAN - this is not the individual doctors NPI
- Provider Transaction Access Number (PTAN)—this is your DME supplier number issued to your company by the National Supplier Clearinghouse
- Tax Identification Number (TIN)—the last five digits of your tax ID

**To research Claim Denials Suppliers Must Have the Following Information**
- Medicare number
- Beneficiary’s Name—we require the full name including prefix or suffix for example Sr. or Jr.
- Date of birth—this is needed for eligibility based denials
- Denial reason—this can be obtained from your remit or by calling the IVR under claim status
- Date of Service of claim in question

**Contact the PCC During Nonpeak Hours**

Due to high call volumes, you may experience longer wait times when contacting the PCC. Therefore, it is recommended that you try calling during nonpeak hours, which is typically between 8:30 a.m.–11:00 a.m. or 12:30 p.m.–2:30 p.m. ET.

**Remember CCRs Are Not Able To**
- Provide claim status, beneficiary eligibility, or any other information that is available through the IVR system;
- Provide information on what modifiers, diagnosis codes, current procedural terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) to use for specific claims or beneficiaries;
- Preauthorize any type of service or supply; and
- Answer inquiries from beneficiaries or their representatives.
Suppliers should also consider using our free Web-based application, NGSConnex as an alternative to the IVR. NGSConnex offers superior search capabilities that make it fast and easy to find the information you need without having to place calls to the PCC or IVR.

**Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor Fourth Quarter 2013 Supplier Telephone Inquiries**

National Government Services has included a review of the top telephone inquiries for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the fourth quarter of calendar year 2013 (October–December). The Provider Outreach and Education team works closely with the Provider Contact Center (PCC) to develop educational materials to ensure the supplier community is knowledgeable on the top telephone inquiries. The National Government Services PCC received 60,446 telephone inquiries for the fourth quarter of 2013. Following is a list of the top ten Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) supplier telephone inquiries for the fourth quarter:

1. **Claim Denials – Medical Necessity (6,555)**

Suppliers are encouraged to consult the local coverage determinations (LCD) and policy articles (PAs) for individual medical policy coverage criteria, which are located on the National Government Services Web site. For medical necessity denials, suppliers are given the option to submit the claim along with supporting documentation as an appeal request. Suppliers may submit redetermination requests to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

Suppliers may also fax redetermination requests. Suppliers should complete the Medicare DME Redetermination Request Form and fax the redetermination request to 317-595-4737.

Suppliers also have the option to submit redetermination requests via a secure internet portal called NGSConnex. Access to NGSConnex only requires users to have the Internet and an e-mail address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.

2. **Claim Denials – Local Coverage Determination (5,928)**

Verify your claim status by utilizing the interactive voice response (IVR) system, NGSConnex, or Claim Status Inquiry (CSI). Verify your claim was submitted to the correct DME MAC. More information regarding claim filing jurisdiction can be found in the Jurisdiction B DME MAC Supplier Manual, Chapter 11. If the claim is not on file and you submitted a paper claim, please resubmit the claim. If the claim is not on file and you submitted an electronic claim, contact your software vendor.

3. **Claim Status – Payment/Explanation/Calculation (4,440)**

DMEPOS items and/or services are paid based on three payment methodologies: (1) fee schedules, (2) reasonable charge and (3) drugs and biologicals. Most DME payments are based on a fee schedule. A standard fee is established for each DMEPOS item by state.

The Medicare Pricing, Data Analysis, and Coding (PDAC) Contractor can assist DMEPOS suppliers with locating fee schedule allowable for a particular product by state. In addition, the PDAC is responsible for determining the appropriate Healthcare Common Procedure Coding System (HCPCS) code to use when
submitting DMEPOS claims to Medicare, processing coding verification applications, assigning existing
HCPCS codes to products and maintaining a national drug code (NDC)/HCPCS code crosswalk applicable
to DME billing.

4. Claim Denials – Contractual Obligation Not Met (3,611)

Some claims submitted to the DME MAC reject because the provider did not comply with his or her
Medicare contractual obligation. For example, the claim was presented with missing information (other than
codes or modifiers), the billing was not timely, etc. Providers should reference the Jurisdiction B DME MAC
Supplier Manual, Chapter 12 for instructions on claim completion, as well as claim filing time limits and
other helpful information.

5. Claim Denials – Claim Overlap (3,449)

Some claims submitted to the DME MAC will be denied when the beneficiary was in a home health agency
(HHA) episode, inpatient hospital stay, or a skilled nursing facility (SNF) Part A stay on the date of service
on the supplier’s claim. This is because payment for certain DMEPOS items are included in the
reimbursement for the HHA, hospital, or SNF Part A stay under the consolidated billing rules. Suppliers
may not submit claims to Medicare for certain items provided to a beneficiary when the DMEPOS item
the beneficiary received is covered under the HHA benefit, inpatient hospital benefit, or SNF benefit, nor may
the supplier bill the patient for those items.

When a supplier’s claim overlaps another supplier’s claim for the same or similar dates of service or billing
periods due to an error in another supplier’s billing, the supplier may contact the PCC for assistance at
866-590-6727. The supplier must be prepared to provide his/her name, National Provider Identifier (NPI),
Provider Transaction Access Number (PTAN), last five-digits of the Tax Identification Number (TIN),
beneficiary name, Health Insurance Claim Number (HICN), and date of service for postclaim information,
or date of birth for preclaim information.

6. Entitlement – Same/Similar (2,462)

Claims submitted for items that are the same or similar to equipment already being used by the beneficiary
will deny with ANSI code CO-151 (Equipment is the same or similar to equipment already being used). To
avoid this denial, suppliers should evaluate the patient’s history during the intake process to determine if
the same, or similar equipment, was previously obtained by the patient. Suppliers may utilize NGSSConnex,
CSI or the IVR system at 877-299-7900 to determine if the beneficiary’s record indicates he or she already
has the same or similar equipment. If the beneficiary wants the equipment even though they already own
or rent the same or similar equipment, and he or she agrees to be financially liable, the supplier should
have the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN) accepting financial
responsibility for the item since it will not be covered by Medicare. The supplier would then submit the
claim with the GA modifier to indicate an ABN is on file. However, if a claim denies because the patient has
previously received the same/similar equipment, and the supplier was unaware of the previous purchase,
the supplier should refund the beneficiary (if applicable). The supplier may choose to exercise his/her right
to request a redetermination. Redetermination requests may be submitted to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

Suppliers may also fax redetermination requests. Suppliers should complete the Medicare DME
Redetermination Request Form and fax the redetermination request to 317-595-4737.
Suppliers also have the option to submit redetermination requests via a secure internet portal called NGSConnex. Access to NGSConnex only requires users to have the Internet and an e-mail address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.

7. Coding – Modifiers (2,373)

Claims submitted to the Medicare Program with invalid or incorrect HCPCS and modifier combinations will result in a denial due to the claim lacking the information which is needed for complete adjudication with ANSI code CO-16. Claims denied CO-16 are not eligible for a redetermination or reopening request. This is because an initial claim determination could not be made with the coding information submitted. All CO-16 denials must be resubmitted with the complete and correct coding.

For a complete listing of the HCPCS modifiers, please consult the Jurisdiction B DME MAC Supplier Manual, Chapter 14. Special coverage guidelines are published in each individual medical policy. The local coverage determinations and policy articles provide specific instructions for using the informational modifiers listed within the medical policy. The LCDs and policy articles may be accessed through the Medical Policy Center on the National Government Services Web site.

Suppliers may also utilize the Durable Medical Equipment Coding System (DMECS) to verify if the HCPCS code requires a primary pricing modifier. DMECS provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS items, and Centers for Medicare & Medicaid Services (CMS) national fee schedules.

8. Claim Denials – Statutory Exclusion (2,038)

Section 1861(s) of the Social Security Act defines medical services that are covered by Medicare, which in turn are implemented through federal regulations, Medicare manuals, instructions from the CMS and decisions by the individual DME MACs that administer the Medicare program in each jurisdiction. Services that are not included in those definitions or instructions are not covered by Medicare. CMS has provided instructions regarding the general exclusions from Medicare coverage in the CMS Internet-Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter 16 “General Exclusions from Coverage.”

Suppliers are encouraged to review the Jurisdiction B Supplier Manual, Chapter 17 for an overview of denial categories billed to Medicare. Special coverage guidelines are published in individual medical policies which can be found in the Medical Policy Center on the National Government Services Web site. In addition, the LCD and PAs both provide specific instructions when an item or service indicated in the LCD and PA are deemed to be excluded from coverage.

9. Claim Denials – Certification Requirements (1,985)

This denial is given when a claim is submitted with an outdated prescription, Certificate of Medical Necessity (CMN) or DME Information Form (DIF). Suppliers should utilize CSI, NGSConnex, or the IVR unit at 877-299-7900 to verify if the item was previously provided or is on file with Medicare. If the item is on file, CSI, NGSConnex and the IVR will provide the previous supplier’s name and telephone number. Suppliers are encouraged to work with the beneficiary to ensure that equipment and supplies are only provided when they are medically necessary. In this situation, the new supplier would need to validate the discontinuance of the first piece of equipment and determine if a break in billing or break in need has occurred. Claims that deny for this reason must be resubmitted with a current prescription, CMN or DIF.
10. Claim Status – Not on File (1,802)

Verify your claim status by utilizing the IVR, NGSSGConex, or CSI. Verify your claim was submitted to the correct DME MAC. More information regarding claim filing jurisdiction can be found in the Jurisdiction B DME MAC Supplier Manual, Chapter 11. If the claim is not on file and you submitted a paper claim, please resubmit the claim. If the claim is not on file and you submitted an electronic claim, contact your software vendor.

Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor Fourth Quarter 2013 Supplier Written Inquiries

National Government Services has included a review of the top supplier written inquiries for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for the fourth quarter of calendar year 2013 (October–December). The National Government Services Written Correspondence Unit received 4,901 written inquiries for the fourth quarter. Following is a list of the top ten Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) supplier written inquiries for the fourth quarter.

1. Claim Denials – Coding Errors including Modifiers (1,195)

Claims submitted to the Medicare Program with invalid or incorrect Healthcare Common Procedure Coding System (HCPCS) and modifier combinations will result in a denial due to the claim lacking the information which is needed for complete adjudication with American National Standards Institute (ANSI) code CO-16. Claims denied CO-16 are not eligible for a redetermination or reopening request. This is because an initial claim determination could not be made with the coding information submitted. All CO-16 denials must be resubmitted with the complete and correct coding.

For a complete listing of the HCPCS modifiers, please consult the Jurisdiction B Supplier Manual, Chapter 14. Additionally, specific instructions regarding modifier usage is located in the Jurisdiction B Supplier Manual, Chapter 15, “DMEPOS Payment Categories.” For specific instructions on using the informational modifiers listed within the medical policy, please go the Medical Policy Center located on the National Government Services Web site.

Suppliers may also utilize the DME Coding System (DMECS) to verify if the HCPCS code requires a primary pricing modifier. DMECS provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, durable medical equipment prosthetics, orthotics, and supplies (DMEPOS), items and CMS national fee schedules.

2. General Information – Issue Not Identified/Incomplete Information (634)

Suppliers are reminded to include as much detail as possible when submitting a written inquiry to the Jurisdiction B DME MAC Written Correspondence Department. When submitting an inquiry in writing, the following information should be included:

- Beneficiary’s name
- Medicare Health Insurance Claim Number (HICN)
- Service date(s)
- Service/supply rendered
- Charges for the supply/service
- Outline of the problem or questions (be specific)
- Copy of the original remittance, if applicable
All written inquiries should be mailed to the following address:

National Government Services, Inc.
Jurisdiction B DME MAC Correspondence
P.O. Box 6036
Indianapolis, IN 46206-6036

3. Claim Denials – Medical Necessity (541)

Suppliers should refer to each individual medical policy to verify coverage criteria for an item and/or service. The medical policies can be found on the National Government Services Web site. For medical necessity denials, suppliers are given the option to submit the claim along with supporting documentation as an appeal request. Suppliers may submit redetermination requests to the following address:

DME MAC Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

Suppliers may also fax redetermination requests. Suppliers should complete the Medicare DME Redetermination Request Form and fax the redetermination request to 317-595-4737.

Suppliers also have the option to submit redetermination requests via a secure internet portal called NGSConnex. Access to NGSConnex only requires users to have the Internet and an e-mail address. There are no costs associated with using this application. For additional information regarding NGSConnex, suppliers should login to the NGSConnex application.

4. Claim Denials – DMEPOS Issues (534)

Maintenance and Servicing

Medicare covers maintenance and servicing of some DME items depending upon the situation and the benefit category into which the item falls. For detailed information on the coverage and billing of maintenance and servicing, refer to the Jurisdiction B Supplier Manual, Chapter 15.

Break in Need/Break in Service

Under the Medicare Part B Program, monthly rental payments may be made for certain DME that is provided to a beneficiary for a period of continuous use. If there is an interruption in the use/medical need for capped rental equipment, a parenteral and enteral nutrition (PEN) pump, or oxygen equipment that is greater than 60 days plus the days remaining in the month the use ceases, the period of continuous use leading up to the break ends and a new period of continuous use begins when the beneficiary again has a medical need for the equipment. (For oxygen equipment, a new period of continuous use may begin following a break in need that is greater than 60 days plus the days remaining in the last paid rental month, only when that break in need occurs during the 36-month payment period.) Suppliers must provide break-in-need/break-in-service (BIS) information on claims following a break in need to identify that a new capped rental period is beginning. A physician’s order, new initial Certificate of Medical Necessity (CMN), if applicable, new testing, if applicable, and all medical necessity criteria must be met as outlined in the local coverage determination (LCD).

Suppliers who have an Administrative Simplification Compliance Act (ASCA) waiver on file should utilize the Jurisdiction B DME MAC Break-in-Service Form and submit it with their CMS-1500 claim form.

For suppliers submitting claims electronically, the BIS information is reported in the Note (NTE) segment in the order and format as follows:
Order:

1. The abbreviation “BIS” for break in service/break in need
2. The “pick up” date and the “delivery” date
3. The beneficiary’s previous ICD-9-CM diagnosis code and the new ICD-9-CM diagnosis code
4. The “pick up” date refers to the date the new and/or previous supplier removes the piece of equipment from the patient’s home. The “delivery” date will be the most recent date the new item was delivered.

Format: BIS MMDDYY MMDDYY ICD-9 ICD-9

For detailed information pertaining to interruptions in a period of continuous use (break in need/break in service), refer to the Jurisdiction B Supplier Manual, Chapter 15.

5. Claim Status – Claim Status (311)

The Jurisdiction B DME MAC telecommunications system is equipped with an interactive voice response (IVR) system. Suppliers can obtain claim status information from the IVR from 7:00 a.m. to 6:00 p.m. eastern time (ET), Monday through Friday, and 7:00 a.m. to 3:00 p.m. ET most Saturdays by calling 877-299-7900. For additional information regarding the IVR unit, suppliers should refer to the IVR user guide.

All suppliers submitting claims electronically or on paper are eligible for Claim Status Inquiry (CSI). This applies to participating and nonparticipating suppliers. With access to CSI, submitters can view the status of all claims as they appear in the DME MAC claims processing system. This includes paid, denied, and pending claims.

NGSConnex is a Web application aimed at suppliers and offering access to a wide array of Medicare information. This application will help answer questions, address Medicare issues, assist in solving problems, and will guide suppliers to business forms. NGSConnex is a free service available to all Jurisdiction B DME MAC suppliers.

A Rules of Behavior Document, Quick Steps Job Aid, and NGSConnex training materials are available at the NGSConnex Web site. These documents should be reviewed prior to registering in this application.

6. Return to Provider Unprocessable – Submitted to Incorrect Program (266)

The traditional fee-for-service Medicare Program consists of two parts: Part A, Hospital Insurance and Part B, Medical Insurance. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Part B covers doctors’ services, outpatient care, some of the services of physical and occupational therapists, some home health care, and medically necessary DMEPOS. Suppliers should refer to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publications for Medicare coverage criteria requirements of items and services specific for each Medicare Program. The CMS IOM Publications are located on the CMS Web site.

7. Claim Denials – Duplicate (247)

The Jurisdiction B DME MAC receives a large quantity of claims that result in duplicate denials. The duplicate claim submission is often the number one claims submission error. Generally claim submission errors are services/items previously processed for the same patient, date of service, and HCPCS code.

Suppliers are reminded to allow 14 days for electronically submitted claims and 29 days for hard copy claims before resubmitting a claim to the DME MAC. Suppliers should utilize CSI, NGSConnex, or the IVR system at 877-299-7900 before resubmitting the claim for payment.
If you received a duplicate claim denial for an item that is not an actual duplicate item, you may request an appeal. Submit supporting documentation along with your appeal request, within 120 days from the date of the initial determination, to the following address:

National Government Services, Inc.
P.O. Box 6036
Indianapolis, IN 46206-6036

You may also utilize NGSConnex to submit an appeal. More information regarding NGSConnex is available on the National Government Services Web site.

For additional information regarding steps to take to avoid duplicate denials, please review the article titled “How To Prevent Duplicate Claim Denials” on the National Government Services Web site.

8. Claim Denials – Medicare Secondary Payer (154)

Suppliers should utilize the Medicare Secondary Payer Questionnaire (MSPQ) when services are provided to a Medicare beneficiary. When correctly completed, the MSPQ will assist suppliers in determining the correct primary payer. The supplier must always determine if the nature of the services are accident-related. If so, the supplier must then determine if no-fault or liability insurance is available. If either insurance is available, the supplier must bill the insurer for 120 days or until a denial is received before billing Medicare. For more information on MSP, visit the Medicare Secondary Payer Web page on the National Government Services Web site. Suppliers are also encouraged to review the CMS IOM Publication 100-05, Medicare Secondary Payer Manual.

9. RTP/Unprocessable – Missing/Invalid Diagnosis (143)

The diagnosis code is required when submitting a claim to Medicare and is reported on the Medicare CMS-1500 paper claim in Item 21 or the corresponding segment of the electronic claim format. It is the supplier’s responsibility to code the diagnosis to the highest specified ICD-9-CM code. If suppliers are unable to determine the highest level of specificity, the supplier is encouraged to contact the ordering physician. If claims received are not coded to the highest level of specificity, the claim will be returned to the supplier as unprocessable. The supplier must correct the diagnosis code and resubmit the claim.

The diagnosis pointer is also required and must be reported in Item 24e of the CMS-1500 paper claim form or the corresponding segment of the electronic claim format. In Item 24e (or the corresponding segment of the electronic format), the supplier must indicate the number that corresponds to the diagnosis code reported in Item 21 that supports the need for the item being billed on that line. The supplier must enter only one number 1, 2, 3, or 4 in item 24e.

10. General Information – Other Issues (97)

To stay up-to-date with the most recent Medicare news, changes and updates, suppliers are encouraged to register for the Jurisdiction B DME MAC E-mail Updates. This free service will send all Medicare news electronically, directly to your e-mail account.
**Power Wheelchair – Third Quarter 2013 Widespread Prepayment Review Update**

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Medical Review Department continues to conduct a widespread prepayment medical review for all group 2 power wheelchairs that do not possess the capability of adding a power seating option (K0820–K0829). This prepayment review also includes power wheelchair related options and accessories. Submitted claims from multiple suppliers were reviewed to assure that all coverage criteria and documentation requirements were met.

Between July 1, 2013 and September 30, 2013, the Jurisdiction B DME MAC processed 636 claims for K0820–K0829 power wheelchair bases with options and accessories. The Jurisdiction B DME MAC Medical Review Department examined 572 claim lines that were developed for additional documentation. Of these claims reviewed, 146 were paid in full. The remaining claims were completely or partially denied resulting in a 77 percent claims error rate.

The most common reasons group 2 power wheelchairs (K0820–K0829) were denied during the third quarter of 2013 are listed below.

1. Documentation of the face-to-face examination failed to prove a manual wheelchair would not meet the beneficiary’s mobility needs in the home.

2. Documentation of the face-to-face examination failed to prove why a power operated vehicle wouldn’t meet the beneficiary’s mobility needs in the home.

3. Documentation of the face-to-face examination did not prove that the beneficiary had a significant mobility limitation requiring a power wheelchair.

Suppliers failed to respond 64 times to requests for additional information to support wheelchair medical necessity. Suppliers are reminded that failure to respond to requests for additional documentation is in violation of supplier standard #28, which states the following:

> Medicare regulations (42 C.F.R §424.516[ff]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial or recoupment of a previously paid claim, but also referral to the National Supplier Clearinghouse (NSC) for possible sanctions.

Suppliers are strongly encouraged to review the following Web site resources in efforts towards quality improvement:

- The LCD and related policy articles for items that are billed by suppliers can be found under Medical Policy Center
- The Policy Education section to review additional information for medical policies
- Chapter 8 of the Jurisdiction B DME MAC Supplier Manual for documentation requirements
In addition, suppliers have free access to CBT courses that have been created by the National Government Services. Power wheelchair suppliers are strongly encouraged to review DME-C-0009, Power Mobility Devices computer-based training (CBT) in order to obtain a better understanding of the local coverage determination (LCD) and policy article. To access this free CBT, go to Medicare University. If you do not have a user ID, click the “Create New User” button.

Suppliers may also consider visiting the Centers for Medicare & Medicaid Services (CMS) Web site for helpful educational information.

**Related Content**

- Medical Policy Center
- Policy Education
- *Jurisdiction B DME MAC Supplier Manual, Chapter 8*
- Medicare University
- CMS Web site

**Power Wheelchair – Fourth Quarter 2013 Widespread Prepayment Review Update**

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Medical Review Department continues to conduct a widespread prepayment medical review for all group 2 power wheelchairs that do not possess the capability of adding a power seating option (K0820–K0829). This prepayment review also includes power wheelchair related options and accessories. Submitted claims from multiple suppliers were reviewed to assure that all coverage criteria and documentation requirements were met.

Between October 1, 2013 and December 31, 2013 the Jurisdiction B DME MAC Medical Review Department examined 613 claim lines for K0820–K0829 power wheelchair bases with options and accessories that were developed for additional documentation. Of these claims reviewed, 124 were paid in full. The remaining claims were completely or partially denied resulting in a 79.8 percent claims error rate.

The most common reasons group 2 power wheelchairs (K0820–K0829) were denied during the fourth quarter of 2013 are listed below.

1. Documentation of the face-to-face examination failed to prove a manual wheelchair would not meet the beneficiary’s mobility needs in the home.

2. Documentation of the face-to-face examination did not prove that the beneficiary had a significant mobility limitation requiring a power wheelchair.

3. Documentation of the face-to-face examination failed to prove why a power operated vehicle wouldn’t meet the beneficiary’s mobility needs in the home.

4. Coverage criteria has not been met showing the beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home.

Suppliers failed to respond 58 times to requests for additional information to support wheelchair medical necessity. Suppliers are reminded that failure to respond to requests for additional documentation is in violation of supplier standard #28, which states the following:
“Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial or recoupment of a previously paid claim, but also referral to the National Supplier Clearinghouse (NSC) for possible sanctions.”

Suppliers are strongly encouraged to review the following Web site resources in efforts towards quality improvement:

- The local coverage determination (LCD) and related policy articles for items that are billed by suppliers can be found under Medical Policy Center
- The Policy Education section to review additional information for medical policies
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In addition, suppliers have free access to computer-based training (CBT) courses that have been created by the National Government Services. Power wheelchair suppliers are strongly encouraged to review DME-C-0009, Power Mobility Devices CBT in order to obtain a better understanding of the LCD and policy article. To access this free CBT, go to Medicare University. If you do not have a user ID, click the “Create New User” button.

Suppliers may also consider visiting the Centers for Medicare & Medicaid Services (CMS) Web site for helpful educational information.

**Related Content**

- Medical Policy Center
- Policy Education
- Jurisdiction B DME MAC Supplier Manual, Chapter 8
- Medicare University
- CMS Web site

**RESPIRATORY**

**Breathe NIOV™ – Coding Reminder – Revised January 2014**

Joint DME MAC Publication

This article updates and replaces the previous version published in December 2012.

The Non-invasive NIOV™ by Breathe Technologies, Inc. provides positive pressure inspiratory support for patients using oxygen. This product consists of multiple components – control unit, flow regulator, connecting hose, and nasal interface (pillows). E1352 is an all-inclusive code for this product that includes all components. For the BREATHE NON INVASIVE OPEN VENTILATION (NIOV) SYSTEM, the Healthcare Common Procedure Coding System (HCPCS) code listed below should be used when billing the Durable Medical Equipment Medicare Administrative Contractors (DME MACs):

E1352 – OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE

If pillows and hoses are billed separately for replacement purposes use:
A9900 – (MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE)

Based on clinical data provided by the manufacturer, this item is effective only when used in conjunction with oxygen; therefore, it is classified as an accessory to oxygen equipment. E1352 is not eligible for separate billing as stand-alone DME under this classification.

Oxygen reimbursement is a bundled payment. All options, supplies, and accessories are considered included in the monthly rental payment for oxygen equipment. Oxygen rental is billed using the appropriate code for the provided oxygen equipment. Separately billed options, accessories, or supply items will be denied as unbundling.

Note: Numerous sources, including the manufacturer’s materials and references in published clinical articles, use the term “ventilator” when discussing this device. For Medicare payment purposes, the NIOV™ device is not considered a ventilator or any other type of positive airway pressure device (continuous positive airway pressure [CPAP], positive airway pressure [PAP], etc.). Durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) suppliers must not use HCPCS codes assigned to those products when submitting claims for the NIOV™ device.

Refer to the oxygen and oxygen equipment local coverage determination and related policy article for additional information about documentation, coverage, and coding requirements.

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

Related Content
- PDAC Contact Form
- LCD for Oxygen and Oxygen Equipment (L27221)
- Article for Oxygen and Oxygen Equipment - Policy Article - Effective October 2012 (A47097)

Supplier “Abandonment” of Beneficiaries and Oxygen Equipment

Recently the Centers for Medicare & Medicaid Services (CMS) issued instructions to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) to process claims for replacement oxygen and oxygen equipment in the event that a supplier voluntarily exits the Medicare oxygen business (for example, goes out of business) and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and noncompetitive bid areas.

In these situations, CMS considers the equipment “lost” under the Medicare regulations at 42 Code of Federal Regulation (CFR), Section 414.210(f), which provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment’s reasonable useful lifetime or has been lost, stolen or irreparably damaged. When considering “lost” equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier furnishing replacement oxygen and oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

Obligations of Exiting Supplier

Suppliers voluntarily exiting the Medicare program are reminded that they are in violation of their regulatory and statutory obligations. Section 1834(a)(5)(F)(ii)(I) requires that the supplier that received the 36th month rental payment continue furnishing the oxygen equipment during any period of medical need for the
reminder of the equipment’s reasonable useful lifetime. Further, 42 CFR 414.226(g)(1) requires, barring a few exceptions, that the supplier that furnishes oxygen equipment in the first month during which payment is made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends. As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) supplier standards set forth at 42 CFR 424.535(c). Violations of the supplier standards are reported to the National Supplier Clearinghouse.

Suppliers voluntarily exiting the program must provide a ninety (90) day notice to the beneficiary of their intention to no longer provide oxygen therapy services. This must be provided in writing and must take one of two forms:

1. A letter to the beneficiary notifying them of the supplier’s intention to discontinue oxygen therapy services. The letter must specify a date upon which this will occur; or,

2. Working with the beneficiary, a letter to a new supplier selected by the beneficiary, transferring provision of oxygen therapy services to the new supplier as of a specific date.

**Obligations of New Supplier**

For suppliers who receive beneficiaries from providers who have elected to voluntarily exit the Medicare oxygen business, claims for replacement equipment must:

1. Include the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,

2. Document in the narrative field of the claim that “Beneficiary acquired through supplier voluntarily exiting Medicare Program” or similar statement.

In addition to providing the above information on the replacement equipment claim, in the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement are either:

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier’s services were being terminated; or,
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare Program.

If the new supplier is unable to obtain the documentation required above, the supplier may not append the RA modifier to the claim and may not initiate a new 36-month capped rental period.

Suppliers accepting transfer of beneficiaries are reminded that all Medicare rules apply. This includes obtaining:

1. New order;
2. New initial CMN
   a. Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the initial date. It could be the test result reported on the most recent prior CMN.
   b. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.
3. Medical necessity documentation as outlined in the oxygen LCD.
Suppliers should review the entire oxygen LCD and policy article for additional information on coding, coverage, and documentation requirements.

**Revised: Payment Rules Reminder – Home Oxygen Initial Qualification Testing**

Joint DME MAC Publication

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when the beneficiary meets all of the requirements set out in the oxygen and oxygen equipment local coverage determination (LCD) and related policy article (PA). This article reviews the blood oxygen testing requirements. Refer to the LCD and PA for information on additional payment criteria.

**Qualifying Test Results**

The results of a blood gas study that has been ordered and evaluated by the attending physician are used as one of the criteria for determining Medicare reimbursement.

Medicare classifies qualification results into three groups, regardless of the test methodology used. The following table summarizes the qualifying results for each group.

<table>
<thead>
<tr>
<th>Group</th>
<th>ABG (mm HG)</th>
<th>Oximetry (% Sat)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I</td>
<td>&lt;55</td>
<td>&lt;88</td>
<td>-</td>
</tr>
<tr>
<td>Group II</td>
<td>56-59</td>
<td>89</td>
<td>Additional disease criteria</td>
</tr>
<tr>
<td>Group III</td>
<td>&gt;59</td>
<td>&gt;89</td>
<td>Presumed noncovered</td>
</tr>
</tbody>
</table>

**Qualification Tests**

Blood oxygen levels are used to assess the beneficiary’s degree of hypoxemia. Blood oxygen levels may be determined by either of two different test methods:

- arterial blood gas (ABG) measurement; or,
- Pulse oximetry.

Arterial blood gas measurements are more accurate and therefore are the preferred measurement method. When both ABGs and oximetry are performed on the same day, the ABG value must be used for reimbursement qualification.

Pulse oximetry values may be obtained using a variety of techniques. The LCD describes the following as acceptable oximetry testing methods:

- At rest and awake – often referred to as “spot” oximetry
- During exercise – requires a series of three tests done during a single testing session:
  - At rest, off oxygen – showing a nonqualifying result
  - Exercising, off oxygen – showing a qualifying result
  - Exercising, on oxygen – showing improvement in test results obtained while exercising off of oxygen
- During sleep
  - Overnight sleep oximetry
    May be done in hospital or at home. Refer to the LCD for detailed information about home overnight sleep oximetry.
- Titration Polysomnogram
Must be used for beneficiaries with concurrent (OSA) in order to establish that the beneficiary is in the “chronic stable state”

Refer to the positive airway pressure devices LCD for information about testing for OSA

**Note:** The overnight sleep oximetry and the titration polysomnogram referenced above are **not** the same test as home sleep testing used for the diagnosis of OSA.

### Chronic Stable State

All qualification testing must be performed while the beneficiary is in the chronic stable state (CSS). CSS requires that all of the following be met:

- Other forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required.
- Each patient must receive optimum therapy before long-term home oxygen therapy is ordered.
- It is expected that virtually all patients who qualify for home oxygen coverage for the first time under these guidelines have recently been discharged from a hospital where they submitted to arterial blood gas tests… If more than one arterial blood gas test is performed during the patient’s hospital stay, the test result obtained closest to, but no earlier than two days prior to the hospital discharge date is required as evidence of the need for home oxygen therapy. (Note: this is the only exception to the CSS requirement)

For those patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state, i.e., not during a period of an acute illness or an exacerbation of their underlying disease.

### Qualified Testing Providers

Oxygen qualification testing may only be performed by providers designated as qualified to perform such testing. Testing done by nonqualified entities is not valid for purposes of qualification for Medicare reimbursement for home oxygen. The LCD states:

All oxygen qualification testing must be performed in-person by a physician or other medical professional qualified to conduct oximetry testing. With the exception of overnight oximetry (see below), unsupervised or remotely supervised home testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment.

The qualifying blood gas study must be one that complies with the fiscal intermediary, local carrier, or A/B MAC policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an independent diagnostic testing facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. These prohibitions do not extend to blood gas studies performed by a hospital certified to do such tests.

For purposes of meeting the “qualified provider” criterion, this policy uses a determination based upon two criteria:

1. whether the test performed meets the applicable requirements for Medicare billing of the specific test, and
2. the entity that performed the test meets the applicable requirements for Medicare billing of the specific test.

Note that this does not require that the specific test be actually billed and/or paid, only that the testing entity meet the requirements necessary to perform and bill Medicare for the actual test. The following describes payment scenarios:

- **Under Medicare Part A**
  - During a Part A covered stay payment is bundled such that services rendered are covered under a lump sum payment by Medicare. In this case, oxygen qualification testing performed in a hospital, nursing facility, home health or hospice or other covered Part A episode meets the “qualified provider” standard.
  - Outside of a covered Part A stay, testing done by a Part A provider does not meet the requirement and is not valid for qualification of home oxygen reimbursement unless the entity is also a qualified provider of diagnostic testing or laboratory services for individual testing performed outside of a covered Part A stay.

- **Under Medicare Part B**
  - Testing performed and covered as “incident to” physician services meets the “qualified provider” standard.
  - Laboratory testing is also reimbursed “a la carte” or on a per test basis. The entity performing the specific test must meet the requirements to perform the specific test. Testing done by an entity that meets the requirements to bill for the individual test meets may be used for oxygen qualification.

**Timing of Testing**

For initial qualification testing scenarios, the qualification testing must be performed within the 30 days before the initial date of certification (prescription date).

As described earlier, for oxygen initially prescribed at the time of hospital discharge, testing must be performed within the two days prior to discharge. This two-day prior to discharge rule does not apply to discharges from nursing facilities.

Refer to the LCD, related PA, and the *Jurisdiction B DME MAC Supplier Manual* for additional information concerning the payment rules for reimbursement of oxygen and oxygen equipment.

**Correct Coding – Supplies used with E0446 – Joint DME MAC Publication**

E0446 (Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories) as described in the narrative is all-inclusive. There is no separate reimbursement for any supplies used with this item. This includes items such as tape, dressings, tubing, etc.

If the supplies are billed separately, Healthcare Common Procedure Coding System (HCPCS) code A9900 (Miscellaneous DME supply, accessory, and/or service component of another HCPCS code) must be used.

Claims for supplies used with E0446 will be denied as unbundling.

Claims for E0446 and related items will be denied as not reasonable and necessary. (*Medicare National Coverage Determinations (NCD) Manual* 20.29.C and 270.5)

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) Contractor Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. central time, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC Web site.
Correct Coding Reminder – Monitoring Technology Used with Positive Airway Pressure Devices and Respiratory Assist Devices

Many manufacturers of medical devices are now incorporating technology for monitoring and/or downloading various types of patient data. This information is then made available for review by the healthcare provider, durable medical equipment (DME) supplier, or in some cases, the beneficiary. This technology may be incorporated into the device itself or added as a separate module. Such technologies include, but are not limited to:

- Smart cards and readers
- USB/Thumb drive accessories
- Wired telephonic transmission modules
- Wireless modems

For example, positive airway pressure devices and respiratory assist devices include technology to monitor compliance. This article serves as a reminder for the correct coding of these features.

Suppliers who elect to bill separately for monitoring technology must use Healthcare Common Procedure Coding System (HCPCS) code A9279 (Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified). Code A9279 is to be used whether the monitoring technology is incorporated as part of the base item, supplied as an add-on module or is a stand-alone item. Claims for A9279 are denied as statutorily noncovered.

A9279 is all-inclusive. Use of multiple instances of A9279 to bill separately for individual features is incorrect coding.

Claims billed for monitoring technologies using other not otherwise classified (NOC) codes such as E1399 (Durable medical equipment, miscellaneous) will be denied as incorrect coding.

Refer to the applicable local coverage determination and related policy article for additional information on the coverage and coding of positive airway pressure (PAP) and respiratory assist device (RAD) items.

Positive Airway Pressure Devices – Fourth Quarter 2013 Prepayment Review Results

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Medical Review Department has completed a prepayment TMR of PAP devices for the treatment of obstructive sleep apnea (OSA)/Healthcare Common Procedure Coding System (HCPCS) E0601. A selection of claims based on a targeted service(s), from multiple suppliers, was identified for review. Additional documentation was requested and documentation received was reviewed for medical necessity.

During the time frame of October 1, 2013–December 31, 2013, the Medical Review Department performed a complex review of 388 claims. Out of these claims, 243 claims were denied resulting in a claim error rate of 63 percent.

From the data collected during the fourth quarter, the following were the top specific reasons for these claims being denied as not medically necessary:

- No face-to-face clinical evaluation by the treating physician prior to a sleep test to assess the beneficiary for OSA or to document that the beneficiary continues to use the PAP device
• No documentation that the beneficiary continues to use and benefit from the device for replacement following the five year reasonable useful lifetime
• No documentation of a face-to-face evaluation by the treating physician for replacement following the five year reasonable useful lifetime

There were also 71 claims that denied for failure of the supplier to respond in a timely manner to the request for additional documentation.

Suppliers are strongly encouraged to review the following Web site resources in efforts towards quality improvement:

• The local coverage determinations and related policy articles for items that are billed by suppliers can be found under Medical Policy Center
• The Policy Education section to review additional information for medical policies
• Chapter 8 of the Jurisdiction B DME MAC Supplier Manual for documentation requirements

Suppliers are reminded that failure to respond to requests for additional documentation is in violation of supplier standard #28, which states the following:

"Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial or recoupment of a previously paid claim, but also referral to the National Supplier Clearinghouse (NSC) for possible sanctions."

**New Unprocessable Claim Rejections for Continuous Positive Airway Pressure Device (E0601)**

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) has identified an increase in the number of requests for reopenings for continuous positive airway pressure (CPAP) device (E0601) claims. While the reopening process is available to correct minor errors and omissions it is more cost effective to submit the claim correctly the first time.

Effective April 1, 2014, National Government Services will begin rejecting claims for CPAP equipment and accessories with American National Standards Institute (ANSI) code CO-4, “procedure code is inconsistent with the modifier used, or a required modifier is missing.” when the ICD-9 code indicated on the claim is something other than ICD-9 code 327.23 – Obstructive sleep apnea (adult) (pediatric) and the KX modifier is present.

**KX - Requirements specified in the medical policy have been met**

The local coverage determination (LCD) for PAP devices advises that CPAP devices are covered if the patient has a diagnosis of obstructive sleep apnea (327.23) documented by a sleep test that meets the Medicare coverage criteria. On initial coverage for the first through third months of rental of the E0601, if the beneficiary meets all of the coverage criteria indicated in the Indications and Limitations of Coverage and/or Medical Necessity section of the LCD, suppliers are instructed to add a KX modifier to codes for CPAP equipment and accessories. For continued coverage, claims submitted for the fourth month and any months thereafter, the supplier must also add a KX modifier to codes for CPAP equipment and accessories only if both the “Initial Coverage” criteria and the “Continued Coverage” criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy have been met.
Submission of the KX modifier is not only an indication that the supplier either has documentation on file or access to the documentation required to meet medical necessity, it is also an indication that the policy restricted diagnosis has been met. All DMEPOS suppliers are required to code their claims with the appropriate ICD-9 diagnosis code as indicated in the medical record.

The PAP device LCD require the presence of a KX, GA, GZ, or GY modifier to indicate whether the coverage criteria outlined within that policy are or are not met and whether an ABN has or has not been properly executed. Suppliers are reminded of their right to execute an Advance Beneficiary Notice of Noncoverage (ABN) if the beneficiary does not meet all of the coverage criteria indicated in this policy. Claims rejected with ANSI code CO-4 are not eligible for an appeal or reopening and must be resubmitted with the appropriate diagnosis and modifier combination.

For detailed claims submission and billing instructions, suppliers are encouraged to review the LCD and policy article for PAP devices for the treatment of obstructive sleep apnea.

**Other Durable Medical Equipment**

**Coverage Guidelines for HCPCS E0762**

National Government Services, the Jurisdiction B DME MAC will change the coverage determination on transcutaneous electrical nerve joint stimulation device systems (E0762).

Claims with dates of service on or after December 1, 2013 submitted with Healthcare Common Procedure Coding System (HCPCS) code E0762 will be denied American National Standards Institute (ANSI) CO-50 which states, “this service will be denied as a noncovered service because this is not deemed a ‘medical necessity’ by the payer.”

**Vacuum Erection Devices Probe Prepayment Review Update**

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Medical Review Department conducted a prepayment probe of vacuum erection devices (VEDs). This is a selection of multiple supplier submitted claims based on a targeted service(s) that are reviewed for medical necessity.

Of the 100 claims reviewed and developed for additional documentation, 74 were denied. This accounted for a claims error rate of 74 percent. Below are the top reasons contributing to these denials:

- Medical records from the treating physician fails to sufficiently document medical necessity
  - Cause of erectile dysfunction/impotence
  - Other conditions/diagnosis that may impact sexual function and treatment for these conditions
  - Therapeutic interventions/ tests/ medications related to diagnosis
- Medical records not received
  - Suppliers are required to provide documentation that supports statutory, regulatory, and documentation Medicare requirements
- Proof of delivery
  - Missing proof of delivery documentation
  - Unable to link the shipping invoice with the delivery slip
  - Date of receipt was missing or did not match the date of service
- No documentation received
Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Suppliers should respond timely even if they don't have all the proper documentation being requested.

Currently, there is no medical policy for VEDs. However, VEDs are eligible for coverage under the prosthetic device benefit which stipulates that the device must be used to replace all or part of an internal body organ. In addition to the statutory and regulatory requirements, suppliers are also required to follow documentation requirements.

To assist suppliers with coverage and documentation requirements, a computer-based training (CBT) course was created for suppliers to review and obtain necessary information for VEDs. Based upon the prepayment probe, suppliers who completed the VED CBT had a lower denial rate than the suppliers who did not complete the VED CBT. The VED CBT course is located in Medicare University, which is a free, interactive online system that houses over 50 DME-specific CBTs. Suppliers who bill Medicare for VEDs are strongly encouraged to review this CBT by logging on to Medicare University with your user name and password and select DME-C-0057. By taking this 30-minute course, suppliers will have an understanding of what documentation and medical record information must be submitted in an audit situation.

Suppliers are strongly encouraged to review the following Web site resources in efforts towards quality improvement:

- The Policy Education section to review additional information for medical policies.
- Chapter 8 of the Jurisdiction B DME MAC Supplier Manual for documentation requirements

Suppliers are also reminded that failure to respond to requests for additional documentation is in violation of supplier standard #28, which states the following:

“Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial or recoupment of a previously paid claim, but also referral to the National Supplier Clearinghouse (NSC) for possible sanctions.”

Related Content
- Medicare University
- Policy Education
- Jurisdiction B DME MAC Supplier Manual, Chapter 8

Coding Guideline – K0900 (Custom Durable Medical Equipment, Other Than Wheelchairs)

Joint DME MAC Publication

A new Healthcare Common Procedure Coding System (HCPCS) code, K0900, has been created for use with custom fabricated durable medical equipment other than wheelchairs. 42 Code of Federal Regulation (CFR), Section 414.224(a) describes the requirements for custom fabricated, stating in order to be considered a customized durable medical equipment (DME) item, a covered item (including a wheelchair) must be:

1. Uniquely constructed or substantially modified for a specific beneficiary according to a physician’s description and orders; and,
2. So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

Supplier and manufacturers must remember that the definition of custom fabricated does not include:

1. Items that are measured, assembled, fitted, or adapted in consideration of a patient’s body size, weight, disability, period of need, or intended use (i.e., custom fitted items); or,

2. Items that have been assembled by a supplier, or ordered from a manufacturer, who makes available customized features, modification or components intended for an individual patient's use in accordance with instructions from the patient's physician.

These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes. The use of customized options or accessories or custom fitting of certain parts does not result in equipment being considered as customized.

Section 414.224(b) further provides that the lump-sum payment made for purchase of the customized item is based on the Medicare contractor’s individual consideration and judgment of a reasonable payment amount for each item. The contractor's individual consideration takes into account:

1. Written documentation on the item’s costs (including design, fabrication, and assembly costs), including at least the costs of labor (to the extent that they are reasonable) of those actually performing the customization; and

2. The types of materials (to the extent that they are reasonable) used in custom fabricating or substantially modifying an item.

In order to determine a reimbursement amount, the supplier must provide a detailed description of each phase of the construction process, materials used, the labor skills needed to fabricate or modify the item, etc. (not all-inclusive). When submitting claims for items using K0900 supplier must have in their files:

1. A detailed written order for the item

2. Information from the medical record justifying that the applicable medical necessity requirements from the relevant policy are met

3. Information from the medical record showing the ordering physician’s description of the item to be provided

4. Information from the supplier providing a detailed description of the item provided including a cost breakdown (for time and each material used in fabrication of the item); construction and/or assembly description; and an explanation about why the item should be considered as custom fabricated.

5. This information must be available upon request.

Pricing differentials between the fee for an established HCPCS code and the suppliers cost or desired charge for any item are not a justification for the use of K0900 or any other NOC code such as E1399 (Durable medical equipment, miscellaneous). Correct coding rules require the use of the most specific HCPCS for any item.

For questions about correct coding, contact the PDAC Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. central time, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC Web site.
Revised Payment Rules – Continuous Passive Motion Machines

DME MAC Joint Publication

Medicare covers continuous passive motion (CPM) devices under the durable medical equipment (DME) benefit. Reasonable and necessary (R&N) requirements are set out in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Section 280.1. The NCD states:

Continuous passive motion devices are devices Covered (sic) for patients who have received a total knee replacement. To qualify for coverage, use of the device must commence within 2 days following surgery. In addition, coverage is limited to that portion of the 3-week period following surgery during which the device is used in the patient’s home. There is insufficient evidence to justify coverage of these devices for longer periods of time or for other applications.

Note that CMS has clarified to the DME MACs that in addition to a total knee replacement, a CPM device is also covered following the revision of a major component of a previous total knee replacement (i.e., tibial components or femoral component).

Additional billing instructions are provided in CMS IOM Publication 100-04, Medicare Claim Processing Manual, Chapter 20 Section 30.2.1 which states:

Contractors make payment for each day that the device is used in the patient’s home. No payment can be made for the device when the device is not used in the patient’s home or once the 21 day period has elapsed. Since it is possible for a patient to receive CPM services in their home on the date that they are discharged from the hospital, this date counts as the first day of the three week limited coverage period.

Coding Guidelines

Continuous Passive Motion devices are classified under two HCPCS codes:

- E0935 – Continuous passive motion exercise device for use on knee only
- E0936 – Continuous passive motion exercise device for use other than knee

Recent questions regarding the exact nature of these devices reveal confusion regarding the nature and functionality of these devices. These coding guidelines clarify the types of products described by the CPM codes.

The first test of any durable medical equipment is that it be durable and capable of repeated use over the expected five-year useful life expectancy. Elastic, fabric, single use, or light plastic devices are not durable and do not meet the test for DME.

Secondly, the equipment must be capable of continuous passive motion of the affected limb. These characteristics mean that the device must have inherent within itself the ability to move the affected limb:

- in an appropriate plane of motion
- in a continuous fashion
- at the same rate of speed
- for a prescribed length of time
- with adjustable limits of range of motion
- with an identical range of motion in each cycle
• without any input from the patient by the contralateral or other limbs
• with easily accessible safety or cutoff switches

These characteristics require that the device be electrically powered, either by AC current or battery. Battery powered models must have an AC adapter for long term use. CPM machines must meet all these characteristics in order to be coded as E0935 or E0936.

Patient-controlled stretch devices are not considered CPM devices and must not be billed using codes E0935 or E0936. These devices are considered exercise equipment and are coded A9300.

**Coverage and Documentation**

Based upon the NCD, continuous passive range of motion devices (CPM) are covered by Medicare only if all of the following are met:

CPM treatment is started after a total knee replacement or a revision of a major component of a previously performed total knee replacement. CPMs are not covered after any other type of knee or joint surgery.

CPM treatment must be applied within 48 hours of surgery to be eligible for Medicare coverage.

Claims for items that do not meet these criteria will be denied as not reasonable and necessary.

Coverage is limited to 21 days from the date of surgery. The DME MAC should be billed only for those days of CPM treatment after discharge from the hospital.

The supplier must have a detailed written order signed and dated by the ordering physician in their file prior to submitting a claim for a CPM.

In the event of an audit there must be information in the medical record showing that the coverage criteria are met.

When billing for a CPM (HCPCS code E0935), all of the following documentation must be included with the claim:

• Type of knee surgery performed; and,
• Date of surgery; and,
• Date of application of CPM; and,
• Date of discharge from the hospital

Claims submitted without this required information will be denied as not reasonable and necessary.

Refer to the *Jurisdiction B DME MAC Supplier Manual* for additional information about coverage, coding, and documentation requirements.

For questions about correct coding, contact the PDAC Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. central time, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC Web site.

**Related Content**

- *Jurisdiction B DME MAC Supplier Manual*
- PDAC Web site
Orthotics and Prosthetics/Therapeutic Shoes/Lenses

ORTHOTICS

Billing Reminder: HCPCS Modifiers LT and RT for Orthotics and Prosthetics

When billing for orthotic and prosthetic devices, suppliers are required to code these claims indicating which side of the body the orthotic or prosthetic device is being applied. In most cases, the local medical policies for orthotic and prosthetic devices provide specific instructions as to when the submission of the modifier(s) LT (left) and/or RT (right) is required. When bilateral items are provided on the same date of service, the supplier must append both the modifiers LT and RT on the same claim line and indicate two units of service. Failure to append the required modifier(s) will result in a CO-16 denial due to lack of information required to completely adjudicate the claim.

Medical policies requiring the use of the modifiers LT and/or RT include, but are not limited to, the following:

- Ankle-foot/knee-ankle-foot orthoses
- External breast prosthesis
  - Note: Bras and similar inherently bilateral items (L8000–L8002, L8015) are exempt from the RTLT requirement.
- Eye prosthesis
- Facial prosthesis
- Knee orthosis
- Lower limb prosthesis
- Orthopedic footwear
- Therapeutic shoes, inserts, and/or modifications for persons with diabetes
- Refractive lens
  - Note: The RT and/or LT modifiers must be used with all HCPCS codes in this policy except codes V2020, V2025 and V2600.

For assistance on correct coding please refer to the local coverage determination and policy articles available on the National Government Services Web site.

THERAPEUTIC SHOES

Reminder: Don’t Forget to Include Your Location Modifiers (LT/RT)

The Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) has recently seen an increase of claim denials associated with incorrect coding for diabetic beneficiaries receiving therapeutic shoes.

Per the policy article for therapeutic shoes for persons with diabetes the right (RT) and/or left (LT) modifiers must be used when billing shoes, inserts, or modifications. If bilateral items are provided on the same date of service, bill for both items on the same claim line using the RTLT modifiers and two units of service. Failure to append the required modifier(s) will result in a CO-16 denial due to lack of information required to completely adjudicate the claim.
GLUCOSE MONITORS

Reminder – National Mail Order Suppliers and Testing Supplies

Suppliers selected for national mail order of diabetic testing supplies are reminded of the following regulations governing the provision of testing supplies:

Contract suppliers for diabetic testing supplies must furnish the brand of diabetic testing supplies that work with the home blood glucose monitor selected by the beneficiary. The contract supplier is prohibited from influencing or incentivizing the beneficiary by persuading, pressuring, or advising them to switch from their current brand or for new beneficiaries from their preferred brand of glucose monitor and testing supplies. The contract supplier may not furnish information about alternative brands to the beneficiary unless the beneficiary requests such information. [Emphasis added - See 42 Code of Federal Regulations (CFR) 414.422(e)(3)]

- Physicians have the option of prescribing a specific brand of glucose monitor if the physician determines that the particular brand or mode of delivery would avoid an adverse medical outcome for the beneficiary. If the physician prescribes a specific brand of monitor, the supplier has three (3) options:

  (1) Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner; or,

  (2) Consult with the physician or treating practitioner to find an appropriate alternative brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or

  (3) Assist the beneficiary in locating a contract supplier that can furnish the particular brand.

(See 42 CFR 414.420)

The Centers for Medicare & Medicaid Services (CMS) and the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are monitoring utilization data and will refer to the appropriate contractor(s) for further investigation any National Mail Order supplier who is suspected of violating these and other terms of their contract.

Glucose monitors are covered under the durable medical equipment benefit; therefore, the five-year reasonable useful life (RUL) rules apply. Additional information on RUL and replacement of DME may be found in the CMS Internet-Only Manual Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 110.2. Routine replacement or replacement due to a change in suppliers is noncovered by Medicare.

Related Content

- CMS Internet-Only Manual Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 110.2
Intermittent Catheter Kits (HCPCS A4353) – Fourth Quarter 2013 Prepayment Medical Review Results

National Government Services, the Jurisdiction B DME MAC Medical Review Department has completed a widespread prepayment medical review of intermittent catheterization kits/HCPCS A4353. A selection of claims based on a targeted service(s) from multiple suppliers was identified for review. Additional documentation was requested and documentation received was reviewed for medical necessity.

During the timeframe of October 1, 2013–December 31, 2013, 247 claims were developed for additional documentation. Out of these claims, 233 claims were denied resulting in a claim error rate of 94 percent. Fifty three claims were denied because the requested documentation was not returned within the required timeframe. Below is a comparison of the claim error rate in the first, second, third, and fourth quarters of 2013.

### Claim Error Rate

<table>
<thead>
<tr>
<th>Review Quarter</th>
<th>Number of Claims Reviewed</th>
<th>Claims Error Rate</th>
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</thead>
<tbody>
<tr>
<td>Fourth Quarter 2013</td>
<td>247</td>
<td>94.00%</td>
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<tr>
<td>Third Quarter 2013</td>
<td>594</td>
<td>94.80%</td>
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<tr>
<td>Second Quarter 2013</td>
<td>1,119</td>
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<td>First Quarter 2013</td>
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<td>82.50%</td>
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</tbody>
</table>

The most common denial reasons were associated with coverage criteria. Below outlines the top denial reasons:

- Failure to meet one of the five coverage criteria outlined within the medical policy as listed below
- A valid refill request from the beneficiary was not documented
- Documentation did not show two urinary tract infections within 12 months prior to start of use of A4353
- No history or documentation to show use of sterile intermittent catheter and an individual packet of lubricant

Beneficiaries must have a permanent impairment of urination to meet basic coverage for use of intermittent catheters. In order to qualify for intermittent catheter kits, the beneficiary must meet one of more of the following criteria:

1. The patient resides in a nursing facility,
2. The patient is immunosuppressed
3. The patient has a radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization,
4. The patient is a spinal cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only),
5. The patient had distinct, recurrent urinary tract infections while on a program of sterile intermittent catheterization with A4351/A4353 and sterile lubricant A4332, twice within 12 months prior to the initiation of sterile intermittent catheter kits.

Suppliers are strongly encouraged to review the following Web site resources in efforts towards quality improvement:

- The local coverage determinations and related policy articles for items that are billed by suppliers. These can be found under Medical Policy Center
• The Policy Education section to review additional information for medical policies
• Chapter 8 of the *Jurisdiction B DME MAC Supplier Manual* for documentation requirements

Suppliers are reminded that failure to respond to requests for additional documentation is in violation of supplier standard #28, which states the following:

"Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial or recoupment of a previously paid claim, but also referral to the National Supplier Clearinghouse (NSC) for possible sanctions."

**Related Content**

• Medical Policy Center
• Policy Education
• *Jurisdiction B DME MAC Supplier Manual, Chapter 8*

### Jurisdiction B DME Contact Information

**National Government Services Web Site**

http://www.NGSMedicare.com

• Click the **Select** button under **Jurisdiction B** Durable Medical Equipment (DME) to access the **Durable Medical Equipment Home** page

**HHS OMHA Centralized Docketing**

200 Public Square, Suite 1260
Cleveland, OH 44114-2316

**Advance Determination of Medicare Coverage**

National Government Services
Attn: Medical Review—ADMC
P.O. Box 7018
Indianapolis, IN 46207-7018
Fax 317-595-4759

**Beneficiary Customer Care**

1-800-MEDICARE (1-800-633-4227)
TDD 317-841-4677

**All DMEPOS Paper Claims**

National Government Services
P.O. Box 7027
Indianapolis, IN 46207-7027

**Coordination of Benefits**

Medicare—Coordination of Benefits
P.O. Box 5041
New York, New York 10274-5041
800-999-1118

Customer Care Contact Center
866-590-6727
Interactive Voice Response (IVR) System
877-299-7900

DMEPOS Additional Documentation Requests
P.O. Box 7027
Indianapolis, IN 46207-7027

—Or—

Physical Address
National Government Services, Inc.
Attention DMEPOS ADRs
8115 Knue Road
Indianapolis, IN 46250

Common Electronic Data Interchange (CEDI)
Help Desk 866-311-9184
NGS.cedihelpdesk@wellpoint.com

Hours: 9:00 a.m.—7:00 p.m. eastern time (ET)
Monday–Friday

Electronic Data Interchange (EDI)
Help Desk (claim status inquiry): 877-273-4334
NGS.EDI.DMAC@anthem.com
Hours: 8:00 a.m.—4:00 p.m. ET
Monday–Friday

Fraud and Abuse
Cahaba Safeguard Administrators, LLC.

Web site http://www.cahabasafeguard.com

Freedom of Information (FOI)
P.O. Box 50454
Indianapolis, IN 46250-0454

Medicare Secondary Payer
(correspondence only)

National Government Services, Inc.
DME MAC MSP
P.O. Box 6036
Indianapolis, IN 46206-6036

Medicare Secondary Payer
(refund checks and refund correspondence)
National Government Services, Inc.
17003 DME MAC MSP
P.O. Box 809305
Chicago, IL 60680-9273

National Supplier Clearing House
P.O. Box 100142
Columbia, South Carolina 29202-3142
866-238-9652

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


Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

Fax Redeterminations
317-595-4737

Refunds
National Government Services, Inc.
17003 DME MAC Non- MSP
P.O. Box 809305
Chicago, IL 60680-9305

Telephone Reopenings
317-841-1307
Monday-Friday 8:00 a.m.–4:00 p.m. ET

Fax Reopenings
317-595-4737

Written Reopenings
P.O. Box 6036
Indianapolis, IN 46206-6036

Written Correspondence
Customer Care Written Correspondence
P.O. Box 6036
Indianapolis, IN 46206-6036
Supplemental Resources

Forms

- Face-to-Face and Written Order Requirements for High Cost DME

Medicare Learning Network Matters Articles

- MM8239—Denial for Power Mobility Device (PMD) Claim from a Supplier of Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) When Ordered By a Non-Authorized Provider
- MM8266—Part B Claims Submission under the Indirect Payment Procedure (IPP)
- MM8297—Use of Claim Adjustment Reason Code 23
- MM8394—Recalcitrant Provider Procedures
- MM8401 Revised—Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims
- MM8426—Applying the Therapy Caps to Critical Access Hospitals (CAHs)
- MM8465—International Classification of Diseases, 10th Revision (ICD-10) Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)
- MM8479—MREP and PC Print Updates for Operating Rules Phase III 360 Rule Compliance
- MM8488—Revised Beneficiary Liability and Messages Associated with Denials for Claims for Services Furnished to Incarcerated Beneficiaries
- MM8509—CMS 1500 Claim Form Instructions: Revised for Form Version 02/12
- MM8518—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 - October 1, 2013 version 3.0.3
- MM8523—Change to the Reasonable Charge Update for 2014 for Splints, Casts, and Certain Intraocular Lenses
- MM8527—Update to Medicare Deductible, Coinsurance, and Premium Rates for 2014
- MM8531—Calendar Year (CY) 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- MM8561—Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) and Medicare Remit Easy Print (MREP) and PC Print Update
- MM8566—Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category
- MM8568—Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2014
- MM8582—Claim Status Category and Claim Status Codes Update
- MM8607—April 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- MM8624—Notice of New Interest Rate for Medicare Overpayments and Underpayments - 2nd qtr Notification for FY 2014
- SE1305 Revised—Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)
- SE1343—Medicare System Project for Electronic Submission of Medical Documentation (esMD)
- SE1344—Further Information on Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims
- SE1406—Registration of Entities Using the Indirect Payment Procedure (IPP)